



# Livingston Parish Public Schools

P.O. Box 1130  
Livingston, Louisiana 70754-1130  
Phone: (225) 686-7044 Fax: (225) 686-4257

<u>Office Use Only</u>	
Physician's Verification Form	
Attached _____	
HR Approval _____	
Other Approval _____	

## REQUEST FOR LEAVE

- Original Request       Extension #1       Extension #2       Amended

**Directions:** Return form to Human Resources. Thirty days notice is required except in case of emergency.

Name: \_\_\_\_\_ Employee Number: \_\_\_\_\_

Address: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

\_\_\_\_\_ Email: \_\_\_\_\_

School: \_\_\_\_\_ Position: \_\_\_\_\_

### Type of LEAVE of ABSENCE Requested:

<b>Begin On:</b> _____ Month/Day/Year – the first day missed	<b>End On:</b> _____ Month/Day/Year – the last day missed
<input type="checkbox"/> * <b>Medical Leave</b> <input type="checkbox"/> * <b>Maternity</b> (90 ESL days are issued in each six year period of employment. Employees may use up to 30 days of that 90 day balance for personal illness related to the maternity leave, if no remaining Accumulated Sick Leave balance exists.) <input type="checkbox"/> * <b>Extended Sick Leave/Catastrophic Illness</b> (A licensed physician must state you, or a member of your immediate family, has a life threatening, chronic or incapacitating condition resulting from catastrophic illness or injury. We reserve the right to request a second opinion from a LPPS approved physician.) <input type="checkbox"/> <b>Military</b> (Please attach a copy of your signed orders to active duty) <input type="checkbox"/> <b>Personal</b> (Please attach statement indicating reason) <b>* Submit separate Physicians Verification Form</b> (Form HR 102P)	

### CHECK ALL THAT APPLY:

- A. Leave with Accumulated Sick Leave days
- B. Extended Sick Leave – ESL (Note: All Accumulated Sick Leave days must be exhausted prior to using ESL days. A licensed physician must state you, or a member of your immediate family, has a life threatening, chronic or incapacitating condition resulting from catastrophic illness or injury. We reserve the right to request a second opinion from a LPPS approved physician.)
- C. Leave Without Pay – LWOP (Contact LPPS Insurance Liaison regarding payment of premiums.)
- D. Other/Combination \_\_\_\_\_

It is my intention to return to my present position on \_\_\_\_\_ (first day after leave ends.)  
MM/DD/YYYY

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Principal/Supervisor's Signature

\_\_\_\_\_  
Date