Livingston Parish Public Schools
Mail Original to: LPPS/Human Resource Department
P.O. Box 1130
Livingston, Louisiana 70754-1130
Phone: (225) 686-7044

Office Use Only

HR _____

SABBATICAL MEDICAL LEAVE

PHYSICIANS VERIFICATION AS REQUIRED BY LOUISIANA REVISED STATUTE 17:1170 et. seq.

THE INFORMATION CONTAINED IN THIS DOCUMENT IS EXEMPT FROM THE PUBLIC RECORD LAWS OF THE STATE OF LOUISIANA.

Name of Patient: _____ Emp. # _____

Exact period for which leave is requested: _____

Name & Address of Physician: _____

_____

Physician's phone number: _____

****

Please complete the following request for information by checking the **YES** or **NO** and/or providing a brief response if appropriate.

1. Have you examined and/or treated this patient during the past two (2) years? ☐ YES ☐ NO
2. Current Diagnosis and date of said diagnosis _____

   _____
3. Based on your current diagnosis:
   (a) Would this condition be considered within the parameters of a contagious or communicable disease? ☐ YES ☐ NO
   (b) Would this condition normally cause the patient to be hospitalized? ☐ YES ☐ NO
   (c) Is recuperation from the effects of this condition possible? ☐ YES ☐ NO
   (d) Does this condition reduce the patient's capabilities in the following areas?
      (1) Vision ☐ YES ☐ NO
      (2) Hearing ☐ YES ☐ NO
      (3) Speech ☐ YES ☐ NO
      (4) Motion ☐ YES ☐ NO

(e) Does this condition prohibit the patient from conducting normal cognitive processes? ☐ YES ☐ NO

(f) Would this condition prohibit the patient from conducting the duties of a teacher? ☐ YES ☐ NO

If yes, then estimate the number of weeks (from the date of diagnosis) that the patient would be unable to perform the duties of his/her profession.

_____Weeks

(g) Based on your diagnosis, could this patient be gainfully employed in any other job or occupation on a part-time (20 hours a week or less) during the period of this sabbatical medical leave? ☐ YES ☐ NO

Please provide any other information which you feel would be pertinent in the School Board's decision process as to whether or not to grant the sabbatical medical leave request made by the patient.

Sabbatical Leave request for Medical Leave applies only to the health of the above applicant, not for attention to family members, and shall be accompanied by a statement from one physician certifying that the health of the applicant is such that the granting of leave would be proper and justifiable. Maternity (remaining home to rear children after delivery) is not an acceptable medical reason.

I, the undersigned, hereby affirm that I am a physician licensed under the laws of the State of Louisiana (or the state of domicile, if different from Louisiana). I further certify under penalty of criminal prosecution (La. R.S. 14:125) that I have examined the herein named patient/applicant for Sabbatical Leave, and have found that the medical condition stated above makes leave applied for herein medically necessary.

_____ _____

NOTE: A signature stamp cannot be accepted. Must be physician's original signature. Nurses or nurse practitioners are NOT authorized to sign.

Date