

**TANGIPAHOA PARISH SCHOOL SYSTEM**  
**EXTENDED SICK LEAVE**

**Please Check One:**

- DUE TO MATERNITY
- DUE TO SURGERY
- DUE TO ILLNESS

***Please indicate which option you wish to take:.***

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{ } I wish to request Extended Sick Leave after all of my accumulated sick leave days are exhausted. I understand that I will receive 65% of my pay at the time the leave begins. I understand that while on Extended Sick Leave, in the event the Board should approve a pay supplement, I will receive fifty percent (50%) of the supplement:

**NOTE: I have confirmed with payroll that I have \_\_\_\_\_ sick days unused.**

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***Please attach a physician's statement which indicates the estimated dates of disability.***

**IMPORTANT - FILL IN THE SPACES BELOW:**

DATE LEAVE STARTS: \_\_\_\_\_

DATE OF RETURN TO WORK: \_\_\_\_\_

**MANDATORY: YOU MUST SUBMIT A DOCTOR'S STATEMENT BEFORE YOU RETURN TO WORK!**

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PLACE OF EMPLOYMENT

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
EMPLOYEE SIGNATURE AND TITLE

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THIS FORM SHOULD BE SENT TO:

Director of Personnel  
Tangipahoa Parish School System  
59656 Puleston Road  
Amite, Louisiana 70422

**SUBMIT A COMPLETED COPY OF THIS FORM TO YOUR PRINCIPAL**

**TANGIPAHOA PARISH SCHOOL SYSTEM**  
**59656 Puleston Road**  
**Amite, Louisiana 70422**  
**Phone: (985) 748-7153**

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**EXTENDED MEDICAL LEAVE**

**PHYSICIAN'S STATEMENT 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**

*Please Print or Type:*

Name of Employee requesting leave: \_\_\_\_\_

Name of Patient (if not employee): \_\_\_\_\_

Relationship to Employee: \_\_\_\_\_

Exact Period for which Leave is requested: \_\_\_\_\_

Physician's Telephone Number: \_\_\_\_\_

Name and Address of Physician: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Please complete the following requested information and provide 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

- |            |   |            |           |
|------------|---|------------|-----------|
| <b>(C)</b> | <b>Is recuperation from the effects of this condition possible?</b>                         | <b>YES</b> | <b>NO</b> |
| <b>(D)</b> | <b>Does this condition prohibit the patient from conducting normal cognitive processes?</b> | <b>YES</b> | <b>NO</b> |
| <b>(E)</b> | <b>Does this condition reduce the patient's capabilities in the following areas?</b>        |            |           |
| <b>(1)</b> | <b>Vision</b>   | <b>YES</b> | <b>NO</b> |
| <b>(2)</b> | <b>Hearing</b>  | <b>YES</b> | <b>NO</b> |
| <b>(3)</b> | <b>Speech</b>   | <b>YES</b> | <b>NO</b> |
| <b>(4)</b> | <b>Motion</b>   | <b>YES</b> | <b>NO</b> |

**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 Extended Medical Leave request made by the patient:**

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**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 for Extended Medical Leave and have found that the medical condition stated above, makes the leave applied for herein medically necessary.**

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**Signature of Physician**  
**(ORIGINAL SIGNATURE ONLY – NO FACSIMILE)**

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**Date Signed**

*PLEASE MAIL THIS FORM TO:*

**Tangipahoa Parish School System  
Personnel Department  
59656 Puleston Road  
Amite, Louisiana 70422**