

APPLICATION FOR SABBATICAL LEAVE

Date _____

TO: President and Members of the Parish School Board
Parish of Tangipahoa - Amite, Louisiana

- * I understand a Sabbatical Leave may only be granted for the period of time contained in the school semester. Therefore, 9 1/2, 10, 11, and 12 month employees must report to work for the contracted period of employment before and/or after the semester for which Sabbatical Leave is granted. I understand that while on Sabbatical Medical Leave, in the event the Board should approve a pay supplement, I will receive fifty percent (50%) of the supplement.

Name of Applicant: _____ Social Security #: _____

Mailing Address: _____ Date of Birth: _____

I have been employed as a teacher continuously in this parish for _____ semesters. I am now employed at _____
_____. I hereby certify that I will spend the period of leave, if granted, in such a manner as to accomplish the purpose herein stated.

Under the provisions of (Act 1342/Sb 297) I submit herewith my application for Sabbatical Leave for

_____ Of the school year _____
(Indicate 1st semester, 2nd semester, or two semesters)

for the period beginning _____ And ending _____
(Month) (Year) (Month) (Year)

For the purpose of: **Professional and Cultural Development Sabbatical**

Complete the Following:

Name and location of College or University to be attended: _____

Name of course(s) of study to be pursued and the number of semester hours of each: _____

Sabbatical Medical Leave

Please check one of the following:

- I do not wish to take any of my accumulated sick leave prior to my Sabbatical beginning
- I wish to take all but 25 days of my accumulated sick leave prior to my Sabbatical beginning
- I wish to take all of my accumulated sick leave prior to my Sabbatical beginning

If leave is for **Sabbatical Medical Leave**, please state symptoms of illness and date symptoms first occurred:

NOTE: A statement from a physician attesting to the need for the Sabbatical Medical Leave must be provided on the attached form and sent directly by the physician to the Tangipahoa Parish School System Personnel Office.

I, the undersigned applicant, do hereby acknowledge that, if this Sabbatical Medical Leave is granted, I will be paid a salary equal to sixty-five (65%) of the salary (which is fixed at the inception of the Sabbatical Leave and will not change during the period of said Sabbatical Leave) that I would receive if I were employed full-time by the Tangipahoa Parish School System at the beginning of the period of this Sabbatical Leave, **less any State Mandated Allocation Adjustments**. I hereby affirm that I will comply with all policies and regulations of the Tangipahoa Parish School System and the laws of the State of Louisiana regarding Sabbatical Leave enumerated in Title 17 of the Louisiana Revised Statutes, as amended.

As a condition of the Sabbatical Medical Leave and to be eligible for compensation during such leave, I the undersigned applicant, do hereby agree to return to service in the Tangipahoa Parish School System for one (1) semester for each semester of Sabbatical Medical Leave which I may be granted herein, and that such service shall begin immediately at the expiration of the Sabbatical Medical Leave period herein requested. I also acknowledge that due to the statutory requirement that failure to return to service for any reason other than incapacitating illness will result in forfeiture of all compensation received during leave.

Applicant's Signature: _____ Date: _____

ACTION OF THE PARISH SCHOOL BOARD:

This application was _____ By the Tangipahoa Parish School Board at a meeting
(Granted or Rejected)

held in _____ On _____ And the teacher was duly notified on _____.

(Signature of Superintendent)

IMPORTANT: For Sabbatical Medical Leave, this application must be sent by certified mail to the attention of the Personnel Director not less than sixty (60) calendar days prior to the starting date for which the Sabbatical Medical Leave application is made. Should an applicant become ill during a semester, the request must be sent by certified mail no less than thirty (30) days prior to the proposed starting date for the Sabbatical Medical Leave.

For Professional and Cultural Improvement Sabbatical Leave, this application must be sent by certified mail to the attention of the Personnel Director not less than sixty (60) calendar days prior to the starting date for which the leave application is made. Those application received less than sixty calendar days before such date may be denied.

TANGIPAHOA PARISH SCHOOL SYSTEM

59656 Puleston Rd.
Amite, Louisiana 70422
Phone: 985.748.7153

SABBATICAL 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 Phone 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

(C) Is recuperation from the effects of this condition possible? YES NO

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

(E) 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 |

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:

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.

Signature of Physician
(ORIGINAL SIGNATURE ONLY - NO FACSIMILE)

Date Signed

PLEASE MAIL THIS FORM TO:

**TANGIPAHOA PARISH SCHOOL SYSTEM
PERSONNEL DEPARTMENT
59656 Puleston Rd.
AMITE, LOUISIANA 70422**