Livingston Parish Public Schools

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

Office Use Only
HR Approval _____
Other Supervisor _____

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:

Begin On: _____ **End On:** _____
Month/Day/Year – the first day missed Month/Day/Year – the last day missed

- ☐ *** Medical Leave**
- ☐ *** Maternity** (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.)
- ☐ *** Extended Sick Leave/Catastrophic Illness** (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.)
- ☐ **Military** (Please attach a copy of your signed orders to active duty)
- ☐ **Personal** (Please attach statement indicating reason)

*** Submit separate Physicians Verification Form** (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

Livingston Parish Public Schools

Mail Original to: LPPS/Human Resource Department
Post Office Box 1130
Livingston, Louisiana 70754-1130
Phone: 225-686-7044

LPPS Office Use Only
HR Approval _____
Received _____

PHYSICIANS VERIFICATION FORM

(Complete top section before presenting to physician.)

EMPLOYEE #: _____ **SOCIAL SECURITY #:** _____

NAME: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information required in the course of my examination or treatment to Livingston Parish Public Schools.

_____ Applicant's Signature _____ Date

TO BE COMPLETED BY PHYSICIAN **Patient's Name** _____

Brief description of illness/condition in layman's terms: _____

_____

_____

Per Louisiana R.S. 17:1202, an employee can be absent from work on approved Extended Sick Leave for a medical necessity. A "Medical necessity" means the result of catastrophic illness or injury, a life threatening condition, a chronic condition, or an incapacitating condition, as certified by a physician, of a teacher or an immediate family member. In your opinion, does the patient's medical condition, injury, and/or illness qualify as a "medical necessity" for Extended Sick leave? ___ Yes ___No

If this leave is for maternity, when is the *Estimated Delivery Date*? _____ **Month/Day/Year**
Will delivery be by C-Section ☐ YES ☐ NO

Patient is under my care and unable to work from _____ **Month/Day/Year – the first day missed** to _____ **Month/Day/Year – the last day missed**

DATE PATIENT WILL BE ABLE TO RESUME FULL DUTIES: _____
(THE LAST DAY MISSED CAN NOT BE THE RETURN TO WORK DAY) **Month/Day/Year – the day to return to work**

Physician's Name (*Please print*): _____ Office Phone #: _____

Office Address: _____ Street City State Zip

Subject to the provisions of Louisiana R.S.14:125, I hereby sign the sworn statement that the information provided above is true and correct.

Physician's Signature:

_____ Date

NOTE: A signature stamp is not acceptable and must be a physician's original signature. Nurses or nurse practitioners are NOT authorized to sign.