FRANKLIN PARISH SCHOOL BOARD *7293 PRAIRIE ROAD* *WINNSBORO, LA 71295* *Phone: (318) 435-9046*	**EXTENDED SICK LEAVE PHYSICIAN'S STATEMENT**

- ***This form must be completed and returned to the Franklin Parish School Board Office within five school days of the absence. No faxes will be accepted.***

Physician's Statement As Required by Louisiana Law.

The Information Contained in this Document is Exempt from the Public Record Laws of the State of Louisiana.

PLEASE PRINT OR TYPE _____   Date: _____

Name of Applicant:_____

Name of Patient: _____

Exact dates for which leave is requested: _____

Please complete the following request for information by circling the yes or no and providing a brief response if appropriate:

1.Have you examined or treated this patient in the last month?   YES: _____   NO: _____

1.Current diagnosis and date of said diagnosis: _____

_____

Based on your current diagnosis, could this patient have performed duties during the dates for which leave is requested?
YES: _____   NO: _____

1.Based upon your examination and diagnosis, would part-time employment of the patient of twenty hours or less per week in any other job or occupation impair the purpose of which the extended sick leave is required?
YES: _____   NO: _____

Please provide any additional information which you feel would be pertinent in the School Board's decision process as to whether or not to grant the extended sick 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/applicant for extended sick leave, and have found that the medical condition stated above makes the leave applied for herein medically necessary.

_____   Address: _____

Signature of Licensed Physician

(ORIGINAL SIGNATURE ONLY - NO STAMPS OR FACSIMILE)   _____

_____ Phone: (_____) _____
Physician Name

Date Signed: _____

FRANKLIN PARISH SCHOOL SYSTEM
APPLICATION FOR EXTENDED SICK LEAVE

_____   _____
NAME   EMPLOYEE ID#

_____   _____
SCHOOL   POSITION

I have used all available accumulated sick leave and am applying for extended sick leave for the days listed below. I understand that I am limited to a **total of 90** extended sick leave days over a six year period of employment and will have my salary reduced in accordance with Franklin Parish policy.

Dates Applying For:

_____

_____

_____

_____

I also understand and I must provide, within **5 _school days_ of the absence**, medical documentation on the official Franklin Parish School Board form with original doctor's signature. Failure to apply within **5 _school days_ of the absense with the official doctor's form attached (no faxes or physician stamped statements)** will result in these days being classified as leave without pay.

_____   _____
EMPLOYEE SIGNATURE   DATE
= =
FOR OFFICE USE ONLY

Last Sick Leave Day Used: _____

_____Approved   _____ Not Approved

_____   _____
Superintendent   Date