

**ST. TAMMANY PARISH SCHOOL BOARD  
APPLICATION FOR SABBATICAL MEDICAL  
LEAVE UNDER LOUISIANA REVISED STATUTE  
17:1170 et. seq.**

**SABBATICAL MEDICAL LEAVE**

Contained within this packet is the information necessary to apply for a Sabbatical Medical Leave. Please note that the first form is a required Physician's Statement. This form must be completed in its entirety by your physician and sent directly by the physician to the Department of Human Resources. (No facsimile is permitted.)

Complete the Sabbatical Medical Leave application form:

- 1.) Retain a copy for your records;
- 2.) Give a copy to your principal/supervisor;
- 3.) The **original** is to be sent by registered mail to the Superintendent of the St. Tammany Parish School System.

**PLEASE MAIL THIS FORM DIRECTLY TO:**

**SUPERINTENDENT  
ST. TAMMANY PARISH SCHOOL BOARD  
POST OFFICE BOX 940  
COVINGTON, LA 70434-0940**



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APPLICATION FOR SABBATICAL MEDICAL LEAVE  
UNDER LOUISIANA REVISED STATUTE  
17:1170 et. seq.**

**SABBATICAL MEDICAL LEAVE**

The undersigned, \_\_\_\_\_,  
(Print Name) (Last) (First) (Middle)

\_\_\_\_\_  
(Date of Birth) (MUNIS Employee Identification Number)

\_\_\_\_\_  
(Street Address, City, State, Zip Code)

presently employed as a/an/the \_\_\_\_\_  
(Grade, Subject, Position)

at \_\_\_\_\_, has completed \_\_\_\_\_ consecutive semesters  
(School/Location) (Number)

in active service in the St. Tammany Parish School System and does hereby make application for Sabbatical

Leave for \_\_\_\_\_ semester(s) beginning \_\_\_\_\_ and ending \_\_\_\_\_.  
(Number) (Effective Date) (Return Date)

Employee's home telephone number: \_\_\_\_\_

Please state the exact manner in which the requested sabbatical leave will be spent:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

I, the undersigned applicant, do hereby acknowledge that, if this sabbatical leave is granted, I will be paid a salary equal to sixty-five percent (65%) of the salary that I would receive if I were employed full-time by the St. Tammany Parish Public School System. I hereby affirm that I will comply with all policies and regulations of the St. Tammany Parish Public 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 this sabbatical leave and to be eligible for compensation during such leave, I, the undersigned applicant, do hereby agree to return to service in the St. Tammany Parish Public 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 further acknowledge that I am prohibited during the period of this sabbatical leave, if granted, to be employed gainfully for more than twenty (20) hours per week. If less than twenty (20) hours per week, any such work must meet all of the requirements of Louisiana Revised Statute 17:1177 and must have been approved by the Board of the St. Tammany Parish Public School System. I further acknowledge that I am prohibited by state law [La. R.S. 17:1177(C)] from being employed during the period of this sabbatical medical leave, if granted, by any public or non-public school system within the United States of America, its territories or possessions.

I further affirm that all statements and representations made herein are true, accurate and correct to the best of my knowledge and belief.

**IMPORTANT:** This application must be sent by registered mail to the attention of the Superintendent not less than sixty (60) calendar days prior to the starting date for which this sabbatical medical leave application is made. Should an applicant become ill during a semester, the request must be sent by certified mail to the attention of the Superintendent not less than thirty (30) days prior to the proposed starting date for the sabbatical medical leave.

**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 ST. TAMMANY PARISH SCHOOL BOARD OFFICE.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date of Completion of this Form

Original-Human Resources

Copy-School or Department

Copy-Employee

**An Equal Opportunity Employer**

Form: PD-25A (Revised: February 2008)