BENSALEM TOWNSHIP SCHOOL DISTRICT

DOROTHY D. CALL ADMINISTRATIVE CENTER
3000 DONALLEN DRIVE BENSALEM, PA 19020
HUMAN RESOURCES DEPARTMENT
(215) 750-2800 ◦ FAX (215) 752-8683

APPLICATION FOR SABBATICAL LEAVE
FOR RESTORATION OF HEALTH

1. Personal information:

Name: _____

Position: _____ Building: _____

2. Certification of eligibility:

I certify that I will have completed at least 10 years of service in the public schools of Pennsylvania at the time the proposed leave would commence.

_____
Initial

I will have completed at least 5 consecutive years of service in the Bensalem Township School District at the time the proposed leave would commence.

_____
Initial

3. Proposed period of leave:

- □ Full year leave: school year 20____ - 20_____
- □ Half year/Semester leave: _____ Semester of the _____ school year
- □ Split leave over two school years (will require specific physician certification if split sabbatical is requested for restoration of health)
  - □ _____ Semester of the _____ school year
  - □ _____ Semester of the _____ school year

4. Restoration of Health: Attached is the completed "Physician's Statement" form attesting to the nature of my sickness/disability and need for leave as outlined in the Pennsylvania Public School Code and Board policy and regulations.

5. Sabbatical Obligations Acknowledgment:

By my signature below, I certify that I make this application in accordance with the School Code, Board Policy, and any applicable Collective Bargaining or other Agreement covering the terms of a sabbatical leave. Furthermore, I acknowledge and agree as follows:

- I agree to and understand my obligation to return to my employment with the Bensalem Township School District for a period of time not less than the period of this leave unless excused due to disability or other excuse consistent with the School Code. If I fail to return, without such an excuse, I understand that I will be required to repay to the school district the salary paid to me during the sabbatical period.

- I understand that if I am required to repay the salary paid to me during the sabbatical period, a mutually agreed upon payment plan will be developed, however, under no circumstances will the repayment schedule go beyond one school year. In addition, I understand and agree that the total cost of health insurance coverage provided to me and, if applicable, to my family during the sabbatical will also be paid back to the School District under the repayment schedule developed.

- I agree to and understand my obligation to submit physician reports periodically which define my condition and compare it with the previous reports and conditions at the time the leave was granted. The reports should also include any hospitalizations, operations, therapy, and/or other treatments.

- I understand that the School District may request that I submit to a medical examination with a Doctor of the School District's choosing and at its expense.

- I understand that I must obtain a return to work certification from my physician prior to being able to resume job duties for the School District.

- I understand that failure to comply with the sabbatical rules and requirements (such as failing to submit required reports) will result in the School District contacting the PA State Employee Retirement System (PSERS) and having the retirement credit for the sabbatical period removed from my retirement account.

Signature: _____ Date: _____

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(District Office Use)

Employee Requesting Sabbatical: Name: ______________________ Building: ______________

Eligibility approved by Director of Human Resources: ___________________ _____________

Signature Date

Approval by Superintendent: ________________________________ _____________

Signature Date

Notification provided to Building Principal: _________________________ _____________

Signature Date

Date Scheduled for Board Agenda: _______________

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PHYSICIAN'S STATEMENT

Patient's name: _____

Please give a detailed statement of patient's:

(a) Nature of illness or disability

(b) Diagnosis

(c) Plan of restoration

(d) In my opinion, the patient will be able to return to full-time employment at the end of the proposed sabbatical leave. _____Yes _____No _____Uncertain

I certify that the patient listed above has been under my professional care, and I have carefully examined said patient, and the the patient will benefit from a medical leave from work during the period of the requested leave.

_____ _____

Name of Physician Signature of Physician

Address of Physician:

_____

_____

Date_____