CITY OF BAKER SCHOOL SYSTEM (CBSS)
SICK LEAVE/EXTENDED SICK LEAVE/FMLA REQUEST
HEALTH CARE PROVIDER FORM
To be completed by Employee AND by the Health Care Provider

To Be Completed by Employee (In Blue Ink) for Employee as the Patient
*Preliminary faxes are temporal; therefore, blue ink original of this form must be scanned & emailed to dgrisby@bakerschools.org with carbon copy to pdecuir@bakerschools or blue ink original can be mailed or hand-delivered.

►Employee Name: _____ ► Date of Request (M/D/Y): _____

►School/Department: _____ ► Job Title: _____

►Home Address: _____

►Home Phone: ( ) _____ ► Cell Phone: ( ) _____

►Requested Beginning Date (M/D/Y): _____ ► Requested Ending Date (M/D/Y): _____
NOTE: Make sure these dates, align with what the physician puts on page 2 of this form!

Teachers can receive **Extended Sick Leave** under **Act 1341** if **ALL** of the following conditions are met:
1. The leave is necessary for illness of the employee or for the care of an immediate family member.
2. All employees' sick leave days have been exhausted at the effective date of the Extended Sick Leave.
3. The Health Care **Provider** portion of this form must be completed by a licensed physician verifying that it is medically necessary for the employee to be absent from work.

NOTE: **Act 788** allows for ninety (90) days of Extended Sick Leave during each six (6) year period of employment after all regular sick leave has been used. This statute requires a showing of a medical necessity. **A Medical Necessity is the result of a catastrophic illness or injury which means a life-threatening, chronic, or incapacitating condition of the school employee or his/her immediate family.** It requires a statement from a licensed physician certifying that it is a medical necessity for the employee to be absent for at least ten (10) consecutive work days. **Act 659** says that the ten (10) consecutive work days does not include classroom teachers. All decisions regarding leave are within the sole authority of the Superintendent.

►**Check AT LEAST one (1) of the following three (3) choices, AS APPROPRIATE (May be one, two, or three):**
___ I wish to request approval of **Regular Sick Leave**. I understand that I will use accumulated Regular Sick Days to cover the estimated time period absent. **I understand that it is my responsibility to read and understand all board-approved policies of the City of Baker School System regarding Sick Leave. OR/AND**

___I wish to request approval of **Extended Sick Leave**. I understand that I must exhaust all of my accumulated Regular Sick Leave first. I understand that I will receive 65% of my pay when Extended Sick Leave begins. It should be noted that Extended Sick Leave pay basically becomes an hourly rate of pay depending on the number of days per pay period; consequently, each paycheck will be different each pay period contingent upon the # of hours per period. The employee should not expect the same amount of pay at 65% each paycheck. Moreover, I understand that it is my responsibility to provide a physician's statement before the leave can be considered for approval. **NOTE**: A request for Extended Sick Leave ideally should be completed before it is taken; however, if this is not possible, the Employee is to follow the time frame established by **Act 788**. **I understand that it is my responsibility to read and understand all board-approved policies of the City of Baker School System regarding Extended Sick Leave. OR/AND**

__ I wish to request approval of **Family and Medical Leave (FMLA)**. I understand that I must exhaust all of my accumulated **Regular Sick Leave** first, followed by the exhaustion of all of my **Extended Sick Leave** in a six year period. I understand that **FMLA** is unpaid leave for up to twelve weeks. Moreover, I understand that it is my responsibility to provide a physician's statement before the leave can be considered for approval. **I understand that it is my responsibility to read and understand all board-approved policies of the City of Baker School System regarding FMLA.**

►Employee Signature: _____ ►Date (m/d/y): _____

NOTE: It is professional courtesy for an Employee to share that the appropriate contents of a Request for Leave with his or her Principal/Immediate Supervisor prior to submission to Human Resources.
_____ **Yes or** ____ **No** Principal/Supervisor Signature: _____ **Date** (m/d/y): _____

_____ Yes or ____ No HR Supervisor Signature: _____ Date: _____

_____ Yes or ____ No Superintendent's Signature_____ Date: _____

►Option #1: To Be Completed by Physician for Employee as Patient

Does the condition of the employee prevent her/him from performing the essential functions of her/his job? _____YES or ____NO If yes, please state the medical facts (condition) and how this condition limits the employee from performing the essential functions of his/her job description:

_____

_____

Provide a general description of the regimen of treatment to be prescribed, a) indicate the # of visits and b) general nature and duration (including estimated dates of recovery period) of treatment to include referrals to other health care providers

_____

_____

Leave dates medically necessary for the Employee to be absent from work (Month, Day, and Year):
Date Leave begins: _____ Date Leave ends: _____
Optional Additional Comments: _____

►Option #2: To Be Completed by Physician for Immediate Family Member As Patient

Please List the relationship of Immediate Family Member Patient to the Employee? _____

Is it medically necessary for our Employee to assist the Immediate Family Member patient? ___ Yes ___ No
Please state the condition which requires the patient to be assisted by our Employee:

_____

_____

As a licensed physician, please state how and why the Employee must assist the immediate family member patient

_____

_____

Provide a general description of the regimen of treatment to be prescribed, a) indicate the # of visits and b) general nature and duration (including estimated dates of recovery period) of treatment to include referrals to other health care providers

_____

_____

Leave dates medically necessary for the Employee to be absent from work (Month, Day, and Year):
Date Leave begins: _____ Date Leave ends: _____
Optional Additional Comments: _____

REQUIRED Signature Authorizations (In Blue Ink)

►Employee's Signature: _____ ►Date (m/d/y): _____
I herby state the above information is true and correct and I authorize Release of the Information requested on this form.

►Health Care Provider Printed Name: _____
►Health Care Provider Signature: _____►Date (m/d/y): _____
►Type of Practice: _____
►Address: _____
►Phone # (Include Area Code): _____ ►Fax # (Include Area Code): _____

PLEASE MAIL COMPLETED FORMS TO THE SUPERVISOR OF HUMAN RESOURCES, David W. Grisby:
CITY OF BAKER SCHOOL SYSTEM (CBSS), P.O. BOX 680, BAKER, LA 70704-0680
***A preliminary faxed copy of this complete form can be faxed to 225/774-5797. Originals can be scanned and emailed to dgrisby@bakerschools.org with carbon copy to Ms. Portia Decuir at pdecuir@bakeschools.org, OR originals can be mailed OR hand-delivered immediately after the preliminary fax!**