

**WEST BATON ROUGE PARISH SCHOOL BOARD**  
**3761 Rosedale Road**  
**Port Allen, LA 70767**  
**Phone (225) 343-8309 \* \* Fax (225) 387-2101**

**PHYSICIAN'S STATEMENT FOR MEDICAL SABBATICAL LEAVE**  
PER LOUISIANA REVISED STATUTE 17:1170 et. seq.

THE INFORMATION CONTAINED IN THIS DOCUMENT IS EXEMPT FROM THE PUBLIC RECORDS LAWS OF THE STATE OF LOUISIANA.

**PLEASE PRINT OR TYPE**

NAME OF PATIENT

\_\_\_\_\_

Last

First

MI

EXACT PERIOD FOR WHICH LEAVE IS REQUESTED

\_\_\_\_\_

PHYSICIAN'S TELEPHONE NUMBER

\_\_\_\_\_

Please complete the following request for information by choosing YES or NO and providing a brief response if appropriate:

1. Have you examined and/or treated this patient during the past two years?  Yes  No

2. Current diagnosis and date of said diagnosis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Based on your current diagnosis:

(a) Would this condition be considered within the parameters of a contagious or communicable disease?  Yes  No

(b) Would this condition normally cause the patient to be hospitalized?  Yes  No

(c) Is recuperation from the effects of this condition possible?  Yes  No

(d) Does this condition reduce the patient's capabilities in the following areas?

- (1) Vision  Yes  No
- (2) Hearing  Yes  No
- (3) Speech  Yes  No
- (4) Motion  Yes  No

(e) Does this condition prohibit the patient from conducting normal cognitive processes?

- Yes  No

(f) Would this condition prohibit the patient from conducting the duties of a teacher?

- Yes  No

(g) Based on your diagnosis, could this patient be gainfully employed in any other job or occupation on a part-time (20 hours a week or less) basis during the period of this sabbatical medical leave?

Please provide any other information which you feel would be pertinent in the School Board's decision process as to whether or not to grant the sabbatical medical leave request made by the patient.

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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 medical leave sabbatical and have found that the medical condition stated above makes the leave applied for herein medically necessary.

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SIGNATURE OF PHYSICIAN  
(ORIGINAL SIGNATURE ONLY – NO FACSIMILE)

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DATE SIGNED