West Baton Rouge Parish School Board
David Corona, Superintendent
3761 Rosedale Road
Port Allen, LA 70767
Phone (225) 343-8309 * * Fax (225) 387-2101

REQUEST FOR SICK LEAVE AND/OR EXTENDED SICK LEAVE
MEDICAL CERTIFICATION FORM - EMPLOYEE AS PATIENT

TO BE COMPLETED BY EMPLOYEE:

EMPLOYEE NAME: ______________________________ SSN: ______________________________

SCHOOL: ______________________________ DATE: ______________________________

ESTIMATED NUMBER OF SICK DAYS REQUESTED TO BE USED: ________ BEGIN: ______________________

ESTIMATED NUMBER OF DAYS REQUESTED TO USE EXTENDED SICK LEAVE: ______________________

TO BE COMPLETED BY LICENSED PHYSICIAN:

Please state the condition which keeps the employee from performing the essential functions of his/her job description.

As a licensed physician, please state HOW this condition limits the employee from performing the essential function of his/her job description.

Describe the regimen of treatment to be prescribed indicating the number of visits, general nature and duration of treatment to include referrals to other health care providers.

Is it medically necessary for the employee to be absent from work? ☐ YES ☐ NO

Beginning Date: ________________ Ending Date: ________________

Any additional comments: ____

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ORIGINAL SIGNATURES ONLY:

EMPLOYEE'S SIGNATURE: ______________________________ DATE ______________________

I HEREBY SIGN THIS SWORN STATEMENT THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT, SUBJECT TO THE PROVISIONS OF LOUISIANA REVISED STATUTE 14:125.

PHYSICIAN'S NAME: ______________________________ TELEPHONE NUMBER: ______________________

PHYSICIAN'S SIGNATURE: ______________________________ DATE ______________________

PLEASE RETURN COMPLETED AND SIGNED MEDICAL CERTIFICATE TO: DEPARTMENT OF HUMAN RESOURCES