Lafayette Parish School System Request for Medical Leave

Employee's Name: _____ Employee ID: _____

Address: _____ City/State/Zip _____

Contact Number: _____ Email Address: _____

School or Department: _____ Position: _____

Select leave desired:

◦ sick leave
◦ leave without pay (**Family and Medical Leave Act**)
◦ maternity leave
◦ extended medical leave

Is this a work-related injury? _____

Date I wish my leave to begin: _____ ***Date I intend to return to work:*** _____

Signature of Supervisor: _____

*Supervisor's signature is required for notification purposes only. This signature is **not** an approval of leave. Supervisor's signature is required before this application will be processed by Human Resources and Risk Management.*

Your physician must complete the medical report on the reverse of this form or provide a medical statement that contains the information requested on the reverse of this form.

Signature of Employee: _____ ***Date:*** _____

For Human Resources Department Use Only:

◦ Leave approved to begin _____ Return to work Date: _____
◦ Leave denied. Reason: _____

Director's signature: _____ Date: _____

Employee notified on _____ By _____

Attachments mailed to employee:

◦ WH-1420
◦ WH-381
◦ Policy GBRI
◦ Other: _____

Accumulated Sick Days: _____
Current Year Sick Days: _____
Personal Days: _____
Total Days Available: _____
Extended Medical Days: _____

Employee eligible for FMLA Yes No

Payroll: Use sick leave days/personal days through _____ then convert to extended medical leave or LWOP.

Revised: 4/23/2015