

CADDO PARISH SCHOOL BOARD
Certified--Human Resources
P.O. Box 32000 (1961 Midway Street)
Shreveport, LA 71130-2000 (71108)
(318)-603-6300

Request for Catastrophic Leave

In the event of catastrophic illness, and only after all current, accumulated and extended sick leave days have been used, an employee may request of the Caddo Parish School Board that he or she be placed on Catastrophic Illness Leave for a period **not to exceed thirty (30) days** in each six year period of employment. The request must be in writing and be accompanied by a written statement of a licensed physician certifying that the leave is medically necessary and that the illness or condition of the employee meets the definition of "catastrophic illness" as defined in CPSB policy GCBD/C. Should the Board, upon review of the request, question the validity or accuracy of the medical certification, the Board may require the employee to be examined by a licensed physician selected by the Board and at the Board's expense to ensure such leave is medically justifiable. Pay while on Catastrophic Illness Leave shall be fifty percent (50%) of the salary being paid to the employee at the time Extended Sick Leave began.

Date _____ Telephone No. _____ (_____)

Name _____ Social Security No. _____ - _____ - _____
(Please Print or Type)

Address _____ Zip Code _____

School/Dept. _____ Position _____

Employment Date _____ Grade/Subject _____
(if applicable)

Period Requested for Leave _____
(provide exact beginning and ending dates)

Reason for Leave Request _____

Physician's Name _____

Physician's Statement Attached Yes No

Employee's Signature

Date

Recommendation of Director of Certified Personnel: Approve Disapprove

If not approved, please state reason _____

Director's Signature

Date

Asst. Superintendent – H.R.'s Signature

Date

Superintendent

Date

CADDO PARISH SCHOOL BOARD
Certified – Human Resources

Catastrophic Leave
Medical Certification

TO BE COMPLETED BY EMPLOYEE

Employee Name: _____ SSN#: _____

School: _____ Date: _____

Number of Days requested to use Catastrophic Leave: _____

Begin: _____ End: _____

TO BE COMPLETED BY LICENSED PHYSICIAN

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

As a licensed physician, please state **how** this condition limits the employee from performing the duties 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 _____

If YES, please indicate the required dates.

Begin: _____ End: _____

COMMENTS: _____

ORIGINAL SIGNATURES

Physician's Name: _____ Physician's Signature: _____
(please type or print)

Physician's Phone Number: _____

INSTRUCTIONS FOR LICENSED PHYSICIAN

Return this completed and signed Medical Certification directly to: Caddo Parish Schools
Certified Personnel
P.O. Box 32000
Shreveport, LA 71130-2000

or fax directly to: (318) 603-7009