



If travel, rather than a course of formal study, is planned, state how such travel will be of educational value in directly improving your skills as a teacher.

---

---

---

Please state and specifically describe below how the course of study [from front page] or travel listed above will enhance your teaching skills.

---

---

---

---

**Read Carefully Before Signing**

I, the undersigned applicant, do hereby acknowledge that, if this sabbatical leave is granted, I will be paid a salary equal to sixty-five percent (65%) of the salary [which is fixed at the inception of the sabbatical leave and will not change during the period of said sabbatical leave] that I would receive if I were employed full-time by the Iberia Parish School System at the beginning of the period of this sabbatical leave. I grant permission and/or authority to the institution(s) named in this application to release my school attendance, course undertaken, grades earned therein, and any other relevant information to officials of the Iberia Parish School System. I further attest and authorize that a photocopy of this application may be considered as an original for purposes of requesting the release of information to the Iberia Parish School System.

As a condition of this sabbatical leave and to be eligible for compensation during such leave, I, the undersigned applicant, do hereby agree to return to service in the Iberia Parish School System for one (1) semester for each semester of sabbatical leave which I may be granted herein, and that such service shall be immediately at the expiration of the sabbatical leave period herein requested.

I further acknowledge that I am prohibited by state law [a. R.S. 17:1177(c)] from being employed part-time or full-time during the period of this sabbatical leave, if granted, by any public or non-public school system within the United States of America, its territories or possessions.

I further affirm that all statements and representations made herein are true accurate and correct to the best of my knowledge and belief.

---

**Applicant's Signature**

---

**Date Signed**



Please state the exact manner in which the requested Sabbatical Medical Leave will be spent:

---

---

---

---

**Read Carefully Before Signing**

I, the undersigned applicant, do hereby acknowledge that, if this Sabbatical Medical Leave is granted, I will be paid a salary equal to sixty-five percent (65%) of the salary [which is fixed at the inception of the sabbatical leave and will not change during the period of said sabbatical leave] that I would receive if I were employed full-time by the Iberia Parish School System at the beginning of the period of this sabbatical leave. I hereby affirm that I will comply with all policies and regulations of the Iberia Parish School System and the laws of the State of Louisiana regarding sabbatical leave enumerated in Title 17 of the Louisiana Revised Statutes, as amended.

As a condition of this sabbatical leave and to be eligible for compensation during such leave, I, the undersigned applicant, do hereby agree to return to service in the Iberia Parish School System for one (1) semester for each semester of sabbatical medical leave which I may be granted herein, and that such service shall begin immediately at the expiration of the sabbatical medical leave period herein requested.

I further acknowledge that I am prohibited during the period of this sabbatical leave, if granted, to be employed gainfully for more than twenty (20) hours per week unless such work meets all of the requirements of Louisiana Revised Statute 17: 1177, and has been approved by the board of the Iberia Parish School System. I further acknowledge that I am prohibited by state law [La. R.S. 17:1177(c)] from being employed during the period of this sabbatical leave, if granted, by any public or non-public school system within the United States of America, its territories or possessions.

I further affirm that all statements and representations made herein are true, accurate and correct to the best of my knowledge and belief.

---

Applicant's Signature

---

Date Signed

**IBERIA PARISH SCHOOL BOARD**  
Post Office Box 200  
New Iberia, LA 70562-0200  
Phone: (318) 365-2341

**SABBATICAL MEDICAL LEAVE FORM**

**Physician's Statement as Required**  
**by Louisiana Revised Statute 17:1170 et. seq.**

**NOTE:** The information contained in this document is exempt from the public record laws of the State of Louisiana.

**PLEASE PRINT OR TYPE**

Name of Patient: \_\_\_\_\_  
(Last) (First) (Middle I.)

Exact period for which leave is requested: \_\_\_\_\_

Name and Address of Physician: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**Please complete the following request for information by circling the 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 patients'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

If **Yes**, then estimate the number of weeks [from the date of the diagnosis] that the teacher would be unable to perform the duties of his/her profession.

\_\_\_\_\_ **Weeks**

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

Sabbatical Medical Leave. Yes No

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

---

---

I, the undersigned, hereby affirm that I am a physician licensed under the laws of the State of Louisiana. I further certify under penalty of criminal prosecution [La. R.S. 14:125] that I have examined the herein named patient/applicant for sabbatical medical leave, and have found that the medical condition stated above makes the leave applied for herein medically necessary.

\_\_\_\_\_  
Signature of Physician (Original Signature Only - No Facsimile)

\_\_\_\_\_  
Date Signed

**PLEASE MAIL THIS COMPLETED FORM DIRECTLY TO THE  
IBERIA PARISH SCHOOL BOARD  
AT THE ADDRESS GIVEN ON THE FRONT OF THIS FORM**

**Thanks!**