Livingston Parish Public Schools

P.O. Box 1130
Livingston, Louisiana 70754-1130
Phone: (225) 686-7044 Fax: (225) 686-4257

Office Use Only
HR Approval _____
Other Approval _____

REQUEST FOR LEAVE

☐ **Original Request** ☐ **Extension #1** ☐ **Extension #2** ☐ **Amended**

Directions: Return form to Human Resources. Thirty days notice is required except in case of emergency.

Name: _____ **Employee Number:** _____

Address: _____ **Home #:** _____ **Cell #:** _____

_____ **Email:** _____

School: _____ **Position:** _____

Type of LEAVE of ABSENCE Requested:

Begin On: _____ **End On:** _____
Month/Day/Year – the first day missed **Month/Day/Year – the last day missed**

- ☐ *** Medical Leave**
- ☐ *** Maternity** (90 ESL days are issued in each six year period of employment. Employees may use up to 30 days of that 90 day balance for personal illness related to the maternity leave, if no remaining Accumulated Sick Leave balance exists.)
- ☐ *** Extended Sick Leave/Catastrophic Illness** (A licensed physician must state you, or a member of your immediate family, has a life threatening, chronic or incapacitating condition resulting from catastrophic illness or injury. We reserve the right to request a second opinion from a LPPS approved physician.)
- ☐ **Military** (Please attach a copy of your signed orders to active duty)
- ☐ **Personal** (Please attach statement indicating reason)

*** Submit separate Physicians Verification Form** (Form HR 102P)

CHECK ALL THAT APPLY:

- ☐ A. Leave with Accumulated Sick Leave days
- ☐ B. Extended Sick Leave – ESL (Note: All Accumulated Sick Leave days must be exhausted prior to using ESL days. A licensed physician must state you, or a member of your immediate family, has a life threatening, chronic or incapacitating condition resulting from catastrophic illness or injury. We reserve the right to request a second opinion from a LPPS approved physician.)
- ☐ C. Leave Without Pay – LWOP (Contact LPPS Insurance Liaison regarding payment of premiums.)
- ☐ D. Other/Combination _____

It is my intention to return to my present position on _____ (first day after leave ends.)
MM/DD/YYYY

_____ _____
Employee's Signature Date

_____ _____
Principal/Supervisor's Signature Date