Terrebonne Parish School Board
Houma, Louisiana

Application for Sabbatical Medical Leave
Under Louisiana Revised Statute
17:1170 et. Seq.

Sabbatical Medical Leave

Important: *This application must be sent by certified mail to the attention of the Superintendent not less than sixty (60) calendar days prior to the starting date for which this sabbatical medical leave application is made. Should an applicant become ill during a semester, the request must be sent by certified mail to the attention of the Superintendent no less than thirty (30) days prior to the proposed starting date for the sabbatical medical leave.*

*Name:*____
(First) *(Middle Initial)* *(Last)*

*Mailing Address:*____

____

Social Security Number of Applicant: ____

List the consecutive semesters of active service in the Terrebonne Parish Public School System (Ex., 1/94-95 through 2/98-99)

Applicant's date of birth: ____

Exact period for which leave is requested: ____

A statement from a physician attesting to the need for the Sabbatical Medical Leave must be provided along With this application.

*Please state the exact manner in which the requested sabbatical leave will be spent:*_____________

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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 Terrebonne Parish Public 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 Terrebonne Parish Public 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 Terrebonne Parish Public 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, and such work meets all the requirements of Louisiana Revised Statute 17:1177, and has been approved by the Board of the Terrebonne Parish Public School System. I further acknowledge that I am prohibited by state law [La. R.S. 17:1177 © from being employed during the period of this sabbatical medical leave, if granted, by any public or non-public school system within the United States of America, its territories, or possessions.

I further acknowledge that TPSB may request a Second Medical Opinion (SMO) with a healthcare provider chosen by TPSB in its sole discretion in connection with this application for Sabbatical Leave and hereby give my consent to submit to a Second Medical Opinion at TPSB request. I understand that it is my responsibility to provide all necessary medical records pertaining to my request for Sabbatical Leave to the physician who will perform the SMO. I further understand that TPSB will schedule the SMO appointment and communicate to me the date, time and place of this appointment.

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 of Completion of this Form*

TERREBONNE
Parish School District

201 Stadium Drive
Houma, LA 70360
(985) 876-7400 / www.tpsd.org

Engage, Educate and Empower Every Student, Every Day

Authorization for Medical and Hospital Records

To Whom It May Concern:

This will authorize you to provide Internal Medicine Group, consisting of Dr. Wade and/or Dr. Chesnut, all medical records and information you may have, without limitation, regarding my medical condition and/or any records or other data that you may have access to regarding my medical condition whether past or present. This access to information is inclusive of, but not limited to, history, findings, diagnostic test results, diagnosis and prognosis. I understand that the information released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the relase and disclosure of this type of information.

This authorization to release records extends to the healthcare provider listed above and such records are provided for the specific purpose of my application for Extended Sick Leave and/or Sabbatical Leave with Terrebonne Parish School Board.

I agree that a photocopy of this authorization may be used as the original. This authorization shall be valid for two years from the date of execution. This authorization may be revoked by me in writing at any time.

______________________	______________________	__________
Print Name	Sign Name	Date

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: INTERNAL MEDICINE GROUP
DR. ALAIN L. E. CHESNUT
DR. CRAIG WADE
Terrebonne General Medical Center
Medical Arts Building, Suite 403
8120 West Main Street
Houma, Louisiana 70360

RE: Patient Name: ____

Date of Birth: __________________ Social Security Number: ______________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with my request for Extended Sick Leave and/or Sabbatical Leave. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All employment, personnel or wage records.

☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of my application for Extended Sick Leave and/or Sabbatical Leave with Terrebonne Parish School Board.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following who have agreed to pay reasonable charges made by you to supply copies of such records:

TERREBONNE PARISH SCHOOL BOARD
201 Stadium Drive
Houma, Louisiana 70360

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

____ ________________________
Signature of Patient or Legally Authorized Representative Date
(See 45CFR § 164.508(c)(1)(vi))

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Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv))

____ ________________________
Witness Signature Date