Monroe City Schools

Packet for Medical or Emergency Leave When Accumulated Sick Days Are Used

All full time employees shall be entitled to a minimum of ten (10) days absence per year because of personal illness or other emergencies without loss of pay. Such leave, when not used, shall be allowed to accumulate to the credit of the employee without limitation.

For every consecutive six (6) days of absence due to personal illness, the employee must present a certificate from a physician justifying the absence. A form for that purpose is included in this packet.

and/or

If the absence involves a major illness requiring an absence 21 or more days the following forms should be submitted to the Human Resource Department prior to taking the leave whenever possible:

1. Have your physician complete the medical certification form. ***This form MUST contain the physicians original signature and cannot be signed by a nurse or a nurse practitioner.***

   You will be notified if a second opinion is required which will be at the expense of the school board.

2. Once your physician says you are medically able to return to work, have him/her complete the Medical Release to Return to Work form and take the completed form to your principal/supervisor upon your return to work.

Monroe City Schools

Human Resources Department
P. O. Box 4180
2006 Tower Drive
Monroe, LA 71211-4180
(318) 325-0601
FAX: 812-3603
Phedra Brantley, Interim Executive Director of Human Resources

Medical Certification

For use when accumulated sick days are used that have exceeded 6 days.

All records regarding medical certification, like all other employee medical records, will be treated as confidential and kept in separate files.

Name:_____ Date:_____

Patient Name (if different from Employee):_____
Relationship to Employee:_____

1.Date on which the serious health condition began:_____

2.The probable duration of the condition:_____

3.Appropriate medical facts concerning the condition:

4.The physician may make any additional comments deemed necessary below:

Physician's Name and Address:

_____

_____

_____

Physician's Signature:

_____

NOTE: A signature stamp cannot be accepted. Must be physician's original signature. ***Nurses or nurse practitioners are not authorized to sign***.