Livingston Parish Public Schools

COVID Official Absence Documentation Form

The information contained in this document is exempt from the Public Record Laws of the State of Louisiana

PART I - To be completed by the employee:

Employee Name		Employee Number	
Position		School or Location	
Phone Number		Alt Phone Number	
Mailing Address			

Select One Qualifying Reason for Leave Related to COVID-19:

- ❑ 1. The employee is subject to a federal, state, or local quarantine or isolation order related to COVID-19.
- ❑ 2. The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. (Physician Completes Part II below)
- ❑ 3. The employee is experiencing symptoms of COVID-19 and is seeking a medical diagnosis. (Physician Completes Part II below)
- ❑ 4. The employee is caring for an individual who is subject to either number 1 or 2 above. (Physician Completes Part II below)
- ❑ 5. The employee is caring for his or her child if the school or place of care of the child has been closed, or the childcare provider of such child is unavailable, due to COVID-19 precautions. (School/Child Care Provider Completes Part III below)
- ❑ 6. The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor. (Physician Completes Part II below)

By signing below, I authorize the release of the information requested below to Livingston Parish School Board as part of my request for COVID leave of absence. My signature also confirms that I understand it is my responsibility to submit this form to Human Resources within three business days of the first day of absence. Failure to submit this form to Human Resources may result in my pay being docked at 100%.	
Employee Signature:	Date:

PART II - To be completed by the physician (reasons 2, 3, 4 or 6 above), please print:

Name of Patient	
Relationship to Employee	
Current Diagnosis (Attach support if possible)	
Supporting Medical Facts	
Period of leave requested	Start Date: End Date:
Physician Name	
Physician Address	
Physician Phone No.	
I, the undersigned, hereby affirm that I am a physician licensed under the laws of the State of Louisiana (or the state of domicile, if different from Louisiana). I further affirm that I have examined the herein named applicant for COVID leave, and have found that the medical condition stated above makes the leave applied for herein medically necessary. I make this statement under *Families First Coronavirus Response Act (FFCRA)*.	
Physician's Signature (No Rubber Stamp Please)	
Date	

PART III - To be completed by the school/child care provider (reason 5 above), please print:

Name of Child(ren)		
Relationship to Child(ren)		
Select One	☐ School	☐ Child Care Provider
Period of closure	Start Date:	End Date:
Name of School/Provider		
School/Provider Address		
School/Provider Phone No.		
I, the undersigned, hereby affirm that I am a school/child care provider for the above named child(ren) . I further affirm that I provide child care services on a regular basis for the above named child(ren) or the above named child(ren) are enrolled in the school listed above. I make this statement under *Families First Coronavirus Response Act (FFCRA)*.		
School/Child Care Provider Signature and Title (No Rubber Stamp Please)		
Date		