

**REQUEST FOR SABBATICAL LEAVE FOR RESTORATION OF HEALTH
ALLENTOWN SCHOOL DISTRICT**

To be completed by the requesting professional or administrative employee

Name:

Mrs.

Ms.

Mr.

Dr.

Last:

First:

M.I.

Address:

Street:

City:

State:

Zip:

School(s):

Position:

Phone Numbers:

School No.

Home No.

Social Security No.

Number of years of satisfactory service as a professional:

Number of consecutive years of service as ASD professional:

Period of Leave

Half school term (one semester)

Full school term (two semesters)

Two half school terms (two semesters) during a period of two years

Half School Terms

Fall

Spring

School Year(s)

I fully understand and agree to abide by the following state and local provisions governing a sabbatical leave.

1. The Pennsylvania School Code, as amended
2. The Collective Bargaining Agreement between the AEA and ASD
3. The policy for Sabbatical Leave for Restoration of Health

To facilitate the district's review of my request, I hereby release my physician and her/his staff to share information about my health, treatment plan, and prognosis with the District's Chief School Physician.

Signature

Date

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ALLENTOWN SCHOOL DISTRICT**

ASD OFFICE USE ONLY:

Date request was Received by Director of Human Resources:

Signature of Chief School Physician:

Date of Approval of Chief School Physician:

Date of School Board Action:

Signature of School Board President:

Signature of Secretary to School Board:

