SICK LEAVE TRANSFER FORM

1. Statement by Transferring Employee

I have accepted employment with the Foothill-De Anza Community College District. I hereby request that you certify to the Foothill-De Anza CCD my accumulated leave of absence for illness or injury, to which I am entitled to under Education Code 87782 (Faculty/Administrators), or Education Code 88202 (Classified).

This is to certify that I, _________________________________ (PRINT NAME), was employed by

Former District: _______________________________________

District Full Address: _______________________________________

District Contact Number: _______________________________________

Employee Signature: ___________________________ Date: ____________

Employee ID or last four digits of SSN: _______________________________________

2. Response by Former District

This is to certify that the above-named person was employed by

___________________________________________________________ (DISTRICT NAME),

from ____/____/______ to ____/____/______ and that the following is true and correct:

TOTAL number of unused sick leave hours to be transferred: _______________________

Name of certifying official (print): ___________________________ Title: ________________

Signature: ______________________________________ Date: __________________

3. Return this form to:

Mail: Office of Human Resources, ATTN: Personnel Services
Foothill-De Anza Community College District, 12345 El Monte Road, Los Altos Hills, CA 94022

Fax: (650) 949-2831, ATTN: Personnel Services