



Office of Human Resources and Equal Opportunity
12345 El Monte Road, Los Altos Hills, CA 94022

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: _____

FHDA PART-TIME TO FULL-TIME (16.22.3)

EMPLOYEE SIGNATURE: _____ DATE: _____

EMPLOYEE CWID: _____

2. RESPONSE BY FORMER DISTRICT

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

_____ (District Name)

from _____ to _____.

Number of Unused Basic Sick Leave Days: _____

Number of Unused Excess Sick Leave Days: _____

TOTAL number of Unused Sick Leave Days to be transferred: _____

Name of certifying official (print) _____ Title: _____

Signature: _____ Date: _____

Email: _____ Phone: _____

3. RETURN THIS FORM TO:

District Office of Human Resources, Attn: Personnel Services
Foothill-De Anza Community College District, 12345 El Monte Rd., Los Altos Hills, CA 94022

or

Fax: (650) 949-2831

7/14/2021