FOOTHILL-DE ANZA
Community College District
Office of Human Resources and Equal Opportunity

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