Office of Human Resources
3401 CSM Drive, San Mateo, CA, 94402
Automated Service Line: (650)574-6555
Fax: (650) 574-6574

REQUEST FOR TRANSFER OF ACCUMULATED ILLNESS AND INJURY LEAVE

(Academic or Classified Employees)

AUTHORITY:
Pursuant to Education Code section 87782 and 87783 (academic employees) and section 88202 (classified employees), individuals who accept employment with the San Mateo County Community College District (SMCCCD) within one year of terminating employment with another community college district, office of a superintendent of schools, or Office of the Chancellor of the California Community Colleges may have transferred to the District his/her accumulated leave for illness and injury ("sick leave"). The separation from employment must have been for reasons other than termination for cause.

Employees who qualify for the transfer of leave described above should complete this form and forward it to an authorized official of the former employer for completion and signature. Once completed, this form is to be returned to the SMCCCD Office of Human Resources at the address above.

SECTION I: to be completed by the employee

Print Name: ____ G#: ___________________

SMCCCD Job Title: _________________________ Effective date of SMCCCD employment: ______

Div/Dept.:_________________________________ at: Cañada Chanc Ofc CSM Skyline

Office Ext.: _______ E-mail: _____________________________________

Former employer name: ____

Address:____________________________________ City, State, Zip Code: _______________________

I accepted employment with SMCCCD within one year of terminating from the above employer, and hereby request transfer of the remaining balance of my accumulated sick leave from my former employer to San Mateo County Community College District.

Employee Signature: _____________________________________ Date: _______

SECTION II: To be completed by authorized official of the former (above) employer

This individual was employed from ______through ______as (last job title):________________________

The position held was (check one): ___academic ___classified. Was this former employee terminated for cause? ___No ___Yes

Remaining balance of accumulated sick leave at the time of termination:

_____ hours OR _____ days

I certify that the above information is true and accurate.

Authorized Official Signature: ___________________________________ Date: _______

Print Your Name: ______________________________________Title:_______________________________

Tel.: __________________________ E-mail: _______________________________________

Employer Name: ____

Address: ________________________________City, State, Zip Code: _______________________________

Comments:

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Once completed and signed, please return this form to San Mateo County Community College District Office of Human Resources.

SECTION III: to be completed by the SMCCCD Office of Human Resources ONLY)

Does the employer and date of termination qualify this employee for sick leave transfer? ___Yes ___No

Comment: ____

Total leave accepted by SMCCCD: _______ Hours OR _______Days

BANNER records updated on (date): _______

Signature: ____ Date: _________
Authorized SMCCCD Official

Distribution: Original to employee HR personnel file; copy to employee