SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Office of Human Resources
3401 CSM Drive San Mateo, CA 94402
Tel: (650) 574-6555 Fax: (650) 574-6574
http://www.smccd.edu/hr

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: ☐ Sky ☐ CSM ☐ Cañada ☐ Chanc Ofc

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 <u>authorized official</u> 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:

_____

_____

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

(Rev. 7/2013)