



SICK LEAVE TRANSFER

Mailing Address: 3222 Winona Way, North Highlands, CA 95660

FAX: 916-566-3597

www.trusd.net

Name of Former Employer

Date

Street Address

Employee Name (print)

City/State/Zip

To Whom It May Concern:

Twin Rivers Unified School District has employed the above-mentioned individual. Please verify unused illness leave and return to the Payroll/Benefits Department as soon as possible.

AUTHORIZATION:

I hereby authorize the verification of unused illness leave to be released to Twin Rivers Unified School District.

Employee Signature

VERIFICATION OF UNUSED ILLNESS LEAVE (California School Districts Only, per Education Code Section §44979-Certificated or Education Code Section §45202-Classified):

The above-mentioned individual was entitled to the following number of accumulated, unused illness leave days/hours upon termination of employment with the district:

One (1) full day of earned sick leave for this employee is based on _____ hours per day.

_____ Number of Days

_____ Number of Hours

Printed Name of School Official

Title

Signature of School Official

Date