

REQUEST TO TRANSFER ACCUMULATED SICK LEAVE

TO FORMER: _____
School District

Address State Zip

FROM: _____
Employee's Name Last 4 of SSN EMPLID

Please transfer the total amount of leave of absence for illness or injury to which I am entitled under Education Code Section 87781/87782 or 88191/88202.

Please email the completed form to PayrollDepartment@palomar.edu (preferred method), or send the form via U.S. Mail to:

Palomar Community College District

Attention: Payroll Services

1140 W. Mission Road

San Marcos, CA 92069

Employee's Signature _____ Date

I _____ certify that _____
Authorized Official Employee's Name
is entitle to _____ days/hours of leave of absence for illness or injury under Section 87781 or 88191 of the Education Code.

Signature of Authorized Official Date