



\_\_\_\_\_  
(Name of Transferring District)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Phone number)

**SUBJECT: VERIFICATION/TRANSFER OF ACCUMULATED SICK LEAVE**

The below employee was previously employed by your District. Please complete and send this form to **Hartnell Community College, Attn: Human Resources Office, 411 Central Avenue, Salinas, Ca 93901 or via email to [benefits@hartnell.edu](mailto:benefits@hartnell.edu).**

\_\_\_\_\_  
(Employee Name)

\_\_\_\_\_  
(Employee SSN#)

\_\_\_\_\_ Employment start date with transferring District

\_\_\_\_\_ Termination Date with transferring District

\_\_\_\_\_ Remaining **days** of accumulated sick leave for certificated service  
(Reference Ed. Code 87782)

\_\_\_\_\_ Remaining **hours** of accumulated sick leave for **classified service**  
(Reference Ed. Code 88202)

I certify the above statement of accumulated sick leave to be true and correct:

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Title)