

EMPLOYEE SICK LEAVE TRANSFER PROGRAM (ESLTP)

Request for Sick Leave Transfer

Name: _____

Date: _____

Full-Time Employee: _____ YES _____ NO

Work Site: _____

Number of Days Requested: _____ (EE must be out 5 days minimum; 60 days maximum use of this program)

Dates of Sick Leave: _____ thru _____

Physician Documentation: _____ YES _____ NO

Information to be posted or distributed to employees:

_____ MEDICAL NECESSITY _____

Location of Posting: _____ Work site only _____ District-wide

Employee Signature: _____

Benefits Specialist Verification: _____

Human Resources Approval: _____