



Request for Sick Leave Balance

_____ Date

TO WHOM IT MAY CONCERN:

_____ has been employed by the Sacramento City Unified School District. We understand this person was employed in your district from _____ (year of employment) until _____ (date of termination).

Would you please certify below the number of days of accumulated unused leave of absence for illness or injury under either Section 45202 or Section 44979 of the Education Code to which this employee was entitled at the time of termination.

If you have any questions, please contact Human Resources at (916) 643-9050. Thank you for your assistance.

I hereby authorize the release of accumulated sick days to the Sacramento City Unified School District.

Requested by New Employee: _____

Signature: _____

Social Security Number: _____

Date: _____

TO: Human Resource Services
Sacramento City Unified School District
P.O. Box 246870
Sacramento, CA 95824-6870

This is to certify that _____ is entitled to _____ hours of accumulated unused leave of absence for illness or injury under either Section 45202 or Section 44979 of the Education Code.

Of the above hours, how many were Excessive Sick Leave Hours: _____

Date of termination: _____

Was termination for cause? _____

Title of position held: _____

I certify that the above information is true and correct.

Administrator responsible for maintaining employee records

Name of District: _____

Street Address: _____

City/State: _____

Telephone: _____