WALNUT VALLEY UNIFIED SCHOOL DISTRICT

HUMAN RESOURCES

M E M O R A N D U M

TO: Paula Dominguez
Human Resources

CERTIFICATED CATASTROPHIC LEAVE

DEPOSIT FORM

NAME OF DEPOSITOR: ____

DEPOSITOR LOCATION: ____

NUMBER OF FULL DAYS TO BE DONATED ______

***Maximum:** 10% of accrued sick leave with the employee maintaining a balance of 25 sick leave days.

☐ **I WISH FOR ______DAYS OF MY ACCRUED SICK LEAVE TO BE DONATED TO ANY CERTIFICATED BARGAINING UNIT MEMBER WHO MEETS THE ELIGIBILITY CRITERIA FOR CATASTROPHIC LEAVE.**

☐ **I WISH FOR ______DAYS OF MY ACCRUED SICK LEAVE TO BE DONATED TO THE FOLLOWING CERTIFICATED EMPLOYEE.**

NAME OF RECIPEINT: ____

RECIPIENT LOCATION: ____

______________________________________ ____________________

Your Signature **Date**

Last updated: October 28, 2015