Clear Form

The School Board of Miami-Dade County, Florida

AUTHORIZATION FOR THE TRANSFER OF ACCRUED SICK LEAVE DAY(S) TO A FAMILY MEMBER

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Employee Transferring the Accrued Sick Leave Day(s):

Employee Name _____ Person ID _____

Cost Center Name _____ Cost Center No. _____

Relationship _____

Number of Accrued Sick Leave Days to be transferred: _____

Pursuant to the provisions of Florida Statute 1012.61, I hereby authorize the Miami-Dade County Public Schools to transfer the above-mentioned number of accrued sick leave days. I certify that the employee receiving my accrued sick leave day(s) is my spouse, child, parent, or sibling, and has exhausted all of his/her sick leave.

NOTE: I understand that I must retain at least ten (10) sick leave days after the transfer.

_____ _____

Employee Signature Date

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Employee Receiving the Transfer of Accrued Sick Leave Day(s):

Employee Name _____ Person ID _____

Cost Center Name _____ Cost Center No. _____

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Relationship verified by:

Cost Center Administrator Name: _____
(Print)

_____ _____
(Signature) Date

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Please send completed form to:

Odalis J. Garces
Mail Code 9321
Payroll Department Room 614 - SBAB

For security purposes, we can only accept ORIGINAL forms - - NO FAXES, NO E-MAILS.