Clear Form

MIAMI-DADE COUNTY PUBLIC SCHOOLS

TRANSFER OF SICK LEAVE DAY BALANCE TO/FROM ANOTHER AGENCY UNDER THE FLORIDA RETIREMENT SYSTEM

>>PLEASE PRINT LEGIBLY AND RETURN ORIGINAL FORM TO THE PAYROLL DEPARTMENT WITH COPY OF DRIVER'S LICENSE<<

Emp. Name: _____ Emp. Number: _____

Soc. Sec. Number: XXX-XX- _____ Date of Birth: _____

Emp. Address: _____ Phone No.: _____

_____

COMPLETE THIS SECTION FOR REQUEST TO TRANSFER DAYS OUT OF MIAMI-DADE COUNTY PUBLIC SCHOOLS:

Name & Address of Receiving Agency:

_____

_____

_____

COMPLETE THIS SECTION FOR REQUEST TO TRANSFER DAYS INTO MIAMI-DADE COUNTY PUBLIC SCHOOLS:
THIS FORM MUST BE COMPLETED UPON RECEIPT OF THE FORMER EMPLOYER'S REQUEST TO TRANSFER DAYS.

Name & Address of Transferring Agency:

_____

_____

_____

- Transferred leave is credited equally to the number of sick days earned with M-DCPS (1:1 ratio.)
- Transferred days/hours will be credited in full day increments. Fraction of days will not be processed.
- Unearned transferred days cannot be utilized until earned, cannot be transferred to another employee, and have no terminal value.
- Unearned transferred days cannot be returned to originating agency. Any unearned transferred days will be forfeited at the time of separation from M-DCPS.
- Earned days will be paid out upon voluntary separation or retirement from M-DCPS, pursuant to Florida Statute 1012.61, Board Policy, and contractual agreements.
- If transferring days to another agency, all earned days will be transferred. NO PARTIAL TRANSFERS.
- Any days transferred to another agency will not be reinstated.
- Employees that separate and have an outstanding payroll overpayment cannot transfer days to another agency.

I hereby acknowledge that I am requesting to transfer sick leave to/from another FRS agency. By giving my authorization below, I understand all the rules and guidelines as noted above. I understand that I may be waiving my rights to any terminal payout, and I also understand that I am bound by the terms and conditions outlined in this document.

_____ _____

Signature Date

FOR OFFICE USE ONLY – DO NOT WRITE IN THIS SPACE	
No. of Sick Days Transferred:	Authorized Signature:
Faxed:	Date Processed: