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# CHARLOTTESVILLE CITY SCHOOLS

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## Sick Leave Transfer Request

This is to certify that \_\_\_\_\_ was employed with  
Employee Name

\_\_\_\_\_ as a(n) \_\_\_\_\_  
School Division Position

He/she has a total of \_\_\_\_\_ hours of sick leave to transfer as of \_\_\_\_\_  
# of hours Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
School Division

\_\_\_\_\_  
Date

**Please fax completed form to the following:  
Attention: Human Resources Department  
Fax: 434.245.2603**