



Intra-District LEAVE TRANSFER REQUEST AND AUTHORIZATION

(Please return completed form to Lisa Lo in Human Resources)

Name of ISD Employee / Donor: _____

ISD Building: _____

Signature: _____

Date: ____ / ____ / ____

Under provision of [WAC 41.04.665](#), I am requesting that you transfer _____ hours of my disability/sick leave to:

(Name of RECEIVING ISD Employee)

I wish my donation to be confidential: Yes No

Employees must maintain 176 hours of disability/sick leave to donate.

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ISSAQUAH SCHOOL DISTRICT #411 HUMAN RESOURCES/PAYROLL USE

_____ Number of hours transferred

_____ Approval of Human Resources

Notes:
