



Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Yvonne B. Burke
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Bruce A. Chernof, MD
Director and Chief Medical Officer

John R. Cochran III
Chief Deputy Director

William Loos, MD
Acting Senior Medical Officer

DHS HUMAN RESOURCES
5555 Ferguson Dr.,
City of Commerce, CA 90022

Tel: (323) 890-7903
Fax: (323) 893-9548

www.ladhs.org

*To improve health
through leadership,
service and education.*



www.ladhs.org

December 15, 2006

TO: Network Executive Council

FROM: Marilyn Hawkins, Personnel Officer III *MWH*

SUBJECT: **CASH REIMBURSEMENT FOR UNUSED SICK LEAVE
JULY 1, 2006, THROUGH DECEMBER 31, 2006**

Attached is the form for employees who wish to buy back sick leave. Eligible employees **must** have completed 12 consecutive months of continuous service by the last day of the period for which the sick leave reimbursement is being requested (i.e., December 31, 2006).

SUBMISSION REQUIREMENTS

The form must be signed and dated by the employee and the employee's supervisor. The supervisor must forward the completed form(s) to the Payroll Office located at DHS Human Resources, 5555 Ferguson Drive, 2nd Floor, Commerce, California 90022, no later than **January 31, 2007**. Issuance of the sick buy back reimbursement will be included on the February 15, 2007, Direct Deposit Pay Warrant.

No time card adjustments will be accepted to qualify an employee for this certification.

If additional forms are required, you may obtain them through your respective timekeeper. If you have any questions, or require additional information, please contact your referenced Payroll Supervisors as listed in the attachment.

CB:cc

M:\Forms\Buy Back Memo 123106.DOC

Attachment

**CERTIFICATION FOR CASH REIMBURSEMENT
FOR UNUSED SICK LEAVE
JULY 1, 2006, THROUGH DECEMBER 31, 2006**

Pursuant to the provisions of Section 6.20.030 (F) of the County Code I,

_____, Employee No. _____,

hereby select to receive cash reimbursement for:

Please check one

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 hours of sick leave (40 hours per week employees)	16 hours of sick leave (40 hours per week employees)	24 hours of sick leave (40 hours per week employees)

I understand that the provisions of Section 6.20.030 (F) require that I must have completed at least 12 consecutive months of continuous service by the last day of the period for which sick leave reimbursement is being requested in order to receive said reimbursement. I must not have used any sick leave during the period commencing July 1, 2006, through December 31, 2006. ***I am not a Megaflex participant***, and this statement is signed and dated by both myself and my immediate supervisor.

This form, with the original signatures, must be returned to the Payroll Office, DHS Human Resources, 5555 Ferguson Drive, 2nd Floor, Commerce, California 90022, no later than January 31, 2007. ***NO FAXED COPIES WILL BE ACCEPTED.***

Said reimbursement shall be paid at the appropriate rate computed in accordance with Section 6.14.060 of the County Code and shall be based on the classification and pay rate I held on December 31, 2006. Further, I understand that electing to receive this reimbursement, I will forfeit all rights to use the hours of sick leave indicated above.

NOTE: Cash reimbursement is subject to the Federal and State withholdings.

Employee's Signature Date

Supervisor's Signature Date