STATE OF CALIFORNIA - CONTROLLER'S OFFICE

INDUSTRIAL/NON-INDUSTRIAL/STATE DISABILITY PAY/ADJUSTMENT REQUEST

STD. 674D (REV. 6/2013)

DOCUMENT NUMBER sample OF 3

TO: STATE CONTROLLER - PPSD / DISABILITY UNIT

1. CBID complete

2. SOCIAL SECURITY NUMBER 111-11-1111

3. F.I. M.I. LAST NAME complete

4. POSITION NUMBER

	AGENCY	UNIT	CLASS	SERIAL
1.	complete	complete	complete	complete
2.				

5. PAY PERIOD

T	MO	YR
0	08	14

6. ENTER NUMBER OF HOURS AND CODE - Intervening activity/working while on Disability [W=Worked; C=Industrial Disability (IDL)] or Dock during the regular period of pay (L=Dock); Please complete if employee is on alternate work schedule before, during, and after Disability

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
											8	8																				

7. INDUSTRIAL DISABILITY (IDL)

a. EMPLOYEE ON IDL FROM: 08/01/2014 THROUGH: 08/31/2014

b. ☐ EMPLOYEE ENTITLED TO ENHANCED IDL

c. AVERAGE HOURS COMPUTED FOR INTERMITTENT EMPLOYEE: _____

8A. NON-INDUSTRIAL DISABILITY (NDI)

a. EMPLOYEE ON NDI FROM: _____ THROUGH: _____

b. AVERAGE HOURS WORKED DURING PREVIOUS 18 MONTHS FOR INTERMITTENT EMPLOYEE WAS: _____

c. ☐ EMPLOYEE ON ANNUAL LEAVE PROGRAM

ELECTED _____ % SUPPLEMENTATION

8B. STATE DISABILITY INSURANCE (SDI)

a. EMPLOYEE ON SDI FROM: _____ THROUGH: _____

b. ☐ EMPLOYEE ELECTED SUPPLEMENTATION

c. SDI WEEKLY RATE: $ _____

9. PAYMENT PER CONTROLLER

ISSUE DATE MO	DY	YR	PT	TIME WORKED DAYS	HOURS	WARRANT OR A/R NUMBER	RET
08	31	14	1	22		complete	
09	07	14			176	complete	

10. PAYMENT SHOULD BE

TYPE	PT	TIME WORKED DAYS	HOURS	TIMEBASE FRACTION
REGULAR	0	2		
SUPPLEMENTAL				
NDI	T			
IDL FULL	6	18		
IDL 2/3	N	2		
IDL / S	U			
SHIFT		**SHIFT CODE**	**HOURS**	**SHIFT RATE**
REGULAR	2	N	16	.50
IDL FULL	6	N	144	.50
IDL 2/3	N	N	16	.50

11. ADDITIONAL INFORMATION

(RETRO APPROVAL , PAYMENT OF SHIFT, TRANSFER OF FUNDS WITH SYSTEM GENERATED A/R)

PLEASE TRANSFER FUNDS

ESTABLISH A/R FOR (number) PAYPERIODS

I hereby certify that the employee named above is entitled to this pay based on the appropriate government codes and/or employee has been notified of the impending account receivable. Prior to submitting this STD 674D, the employee was given a reasonable time to respond.

12. AUTHORIZED SIGNATURE your signature **DATE SIGNED** Oct 17, 2014

your name

(PRINT OR TYPE NAME)

13. CONTACT PERSON (If other than authorized signature)

complete if required

14. TELEPHONE NUMBER

(999) 555-5555

15. EMAIL ADDRESS

complete@...ca.gov