STATE OF CALIFORNIA - CONTROLLER'S OFFICE

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

STD. 674D (REV. 6/2013)

DOCUMENT NUMBER **sample** OF **6(A) 1 OF 2**

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.	518	406	5157	090 (A)
2.				

5. PAY PERIOD

T	MO	YR
0	08	13

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	

7. INDUSTRIAL DISABILITY (IDL)

a. EMPLOYEE ON IDL FROM: _____ THROUGH: _____

b. ☐ EMPLOYEE ENTITLED TO ENHANCED IDL

c. AVERAGE HOURS COMPUTED FOR INTERMITTENT EMPLOYEE: _____

8A. NON-INDUSTRIAL DISABILITY (NDI)

a. EMPLOYEE ON NDI FROM: 07/31/2013 THROUGH: 08/17/2013

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	ISSUE DATE DY	ISSUE DATE YR	PT	TIME WORKED DAYS	TIME WORKED HOURS	WARRANT OR A/R NUMBER	RET

10. PAYMENT SHOULD BE

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

11. ADDITIONAL INFORMATION

IF POSITIONS HAVE DIFFERENT UNIT AND/OR CLASS NUMBERS, A DOCUMENT IS REQUIRED FOR EACH POSITION AND MUST BE SUBMITTED AS A PACKAGE.

SHOW DAYS AND HOURS FOR EACH POSITION
EXAMPLE;
POSITION A 18 DAYS FROM 07/31/13 TO 08/17/13

NOT TO EXCEED MAX IN PAYPERIOD

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** Aug 30, 2013

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

STATE OF CALIFORNIA - CONTROLLER'S OFFICE

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

STD. 674D (REV. 6/2013)

DOCUMENT NUMBER sample OF 6(B) 2 OF 2

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.	518	617	1303	008 (B)
2.				

5. PAY PERIOD

T	MO	YR
0	08	13

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	

7. INDUSTRIAL DISABILITY (IDL)

a. EMPLOYEE ON IDL FROM: THROUGH:

b. ☐ EMPLOYEE ENTITLED TO ENHANCED IDL

c. AVERAGE HOURS COMPUTED FOR INTERMITTENT EMPLOYEE:

8A. NON-INDUSTRIAL DISABILITY (NDI)

a. EMPLOYEE ON NDI FROM: 08/18/2013 THROUGH: 08/29/2013

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

10. PAYMENT SHOULD BE

TYPE	PT	TIME WORKED DAYS	HOURS	TIMEBASE FRACTION
REGULAR	0			
SUPPLEMENTAL				
NDI	T	12		
IDL FULL	6			
IDL 2/3	N			
IDL / S	U			
SHIFT		SHIFT CODE	HOURS	SHIFT RATE
REGULAR	2			
IDL FULL	6			
IDL 2/3	N			

11. ADDITIONAL INFORMATION

IF POSITIONS HAVE DIFFERENT UNIT AND/OR CLASS NUMBERS, A DOCUMENT IS REQUIRED FOR EACH POSITION AND MUST BE SUBMITTED AS A PACKAGE.

SHOW DAYS AND HOURS FOR EACH POSITION
EXAMPLE;
POSITION B 12 DAYS FROM 08/18/13 TO 08/29/13

NOT TO EXCEED MAX IN PAYPERIOD

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** Aug 30, 2013

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