

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

STD. 674D (REV. 6/2013)

DOCUMENT NUMBER sample 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.	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

## 7. INDUSTRIAL DISABILITY (IDL)

a. EMPLOYEE ON IDL FROM: 08/12/2014 THROUGH: 08/31/2014b. ☐ EMPLOYEE ENTITLED TO ENHANCED IDL

c. AVERAGE HOURS COMPUTED FOR INTERMITTENT EMPLOYEE: \_\_\_\_\_

## 9. PAYMENT PER CONTROLLER

ISSUE DATE				PT	TIME WORKED		WARRANT OR A/R NUMBER	RET
MO	DY	YR			DAYS	HOURS		
08	31	14		0	8		complete	

## 11. ADDITIONAL INFORMATION

## 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

## 10. PAYMENT SHOULD BE

TYPE	PT	TIME WORKED		TIMEBASE FRACTION
		DAYS	HOURS	
REGULAR	0	8		
SUPPLEMENTAL				
NDI	T			
IDL FULL	6	14		
IDL 2/3	N			
IDL / 5	U			
SHIFT		SHIFT CODE	HOURS	SHIFT RATE
REGULAR	2			
IDL FULL	6			
IDL 2/3	N			

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

## DATE SIGNED

your signatureSep 1, 2014your 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

## 8B. STATE DISABILITY INSURANCE (SDI)

a. EMPLOYEE ON SDI FROM: \_\_\_\_\_ THROUGH: \_\_\_\_\_

b. ☐ EMPLOYEE ELECTED SUPPLEMENTATION

c. SDI WEEKLY RATE: \$ \_\_\_\_\_