

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: _____

9. PAYMENT PER CONTROLLER

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

10. PAYMENT SHOULD BE

TYPE	PT	TIME WORKED		TIMEBASE FRACTION
		DAYS	HOURS	
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

DATE SIGNED

your signature

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

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: \$ _____