

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

STD. 674D (REV. 6/2013)

DOCUMENT NUMBER sample OF 6

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

## 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

T	MO	YR	31	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
0	08	14	4W 4C	4W 4C			4W 4C	4W 4C	4W 4C	4W 4C	4W 4C			4W 4C	4W 4C	4W 4C	4W 4C	4W 4C			4W 4C	4W 4C	4W 4C	4W 4C	8C			8C	8C	8C	8C	8C		

## 7. INDUSTRIAL DISABILITY (IDL)

## a. EMPLOYEE ON IDL

FROM:

THROUGH:

07/31/2014 08/31/2014b. ☐ 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			PT	TIME WORKED		WARRANT OR A/R NUMBER	RET
MO	DY	YR		DAYS	HOURS		

## 10. PAYMENT SHOULD BE

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

## 11. ADDITIONAL INFORMATION

EMPLOYEE HAS 2 INJURIES  
 CL#XXXXXXXXX DOI 04/31/13  
 CL#XXXXXXXXX DOI 08/21/14

*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