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 | 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 | 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 | | | | TIME WORKED | | WARRANT OR | |
|---|---|---|---|---|---|---|---|
| MO | DY | YR | PT | DAYS | HOURS | A/R NUMBER | RET |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**10. PAYMENT SHOULD BE**

| TYPE | PT | TIME WORKED DAYS | TIME WORKED 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