

VERIFICATION OF SERVICE/SALARY for DISABILITY APPLICATION

The following employee has filed an application an Accidental Disability Retirement. Please complete the following and submit this form with copies of **detailed payroll records** from 12 months prior to date of injury to present.

Name: _____ XXX-XX-_____

Date of Injury: _____ Date of Total Incapacity: _____ Date of Last Regular Compensation* _____

*Regular Compensation includes sick leave, personal/vacation leave, 111F benefits but does not include worker's compensation payments.

Rate of Regular Compensation on Date of Injury:	
Base Salary per pay period: _____	Pay Period _____
Longevity (if not included in base): _____	When regularly paid? _____
Other Regular Compensation (not included in base) e.g. shift differential, public safety holiday pay, public safety educational incentive, public safety hazmat, on-call pay... Specify below or write not applicable	
Holiday Pay _____	When regularly paid? _____
Educational Incentive _____	When regularly paid? _____
Hazmat stipend (only) _____	When regularly paid? _____
Other (specify) _____	When regularly paid? _____
	When regularly paid? _____

Changes to Regular Compensation since Date of Injury	New Amount	Effective Date	New Amount	Effective Date
Base Salary per pay period: _____				
Longevity _____				
Other Regular Compensation (not included in base) e.g. shift differential, public safety holiday pay, public safety educational incentive, public safety hazmaz, on-call pay etc... Specify below or write not applicable				
	New Amount	Effective Date	New Amount	Effective Date
Holiday Pay _____				
Educational Incentive _____				
Hazmat stipend (only) _____				
Other (specify) _____				
Is Member still receiving weekly worker's compensation payments?		Weekly rate?		
Please send record detailing worker's compensation payments received from date of injury to present				
If Member is public safety officer, is he/she receiving 111F benefits?				

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