STATE OF DELAWARE
OFFICE OF PENSIONS

PENSION CREDITABLE COMPENSATION (AGENCY)

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

The Pension Office is responsible for verifying creditable compensation and wages subject to pension contributions; therefore, this form must be completed for all employees who have terminated, deceased, or who have retired on a service, disability or vested pension.

NAME: ______________________________ **PENSION ID:** ____________________

DATE OF: **Retirement** **Death** **Termination** ______________________________

LAST DAY WORKED (if different from above): ______________________________

Indicate number of hours worked per day if not 7.5 hours: __________

Amount of Last Regular Pay:	
Regular Salary	
Overtime	
Holiday	
Comp Time Amount Date/Timeframe Earned: to	
Shift Differential	
Hazard Duty	
Other -	
Total of Last Regular Pay:	
Date Disbursed:	

Amount of Paid Sick Leave:

Number of Hours Accrued ____________

Total # of Hours Paid ________ x Hourly Rate __________ **Total:** ____________

Date Disbursed: ____________

Amount of Paid Vacation Leave:

Total # of Hours Paid ________ x Hourly Rate __________ **Total:** ____________

Date Disbursed: ____________

I CERTIFY THAT THERE ARE NO PAYROLL ADJUSTMENTS PENDING.

______________________________ ______________________________ ____________

AUTHORIZED SIGNATURE **TITLE** **DATE**

Print Name: ______________________________ **Agency Name:** ______________________________