STATE EMPLOYEES
RETIREMENT COMMISSION

MEDICAL EXAMINING BOARD for DISABILITY RETIREMENT

HEALTH CARE COST CONTAINMENT COMMITTEE



STATE OF CONNECTICUT RETIREMENT & BENEFIT SERVICES DIVISION OFFICE OF THE STATE COMPTROLLER

55 ELM STREET
HARTFORD, CONNECTICUT
06106-1775
TELEPHONE (860) 702-348
TELEFAX (860) 702-3489

Employee Number:

Effective Date of Retirement:

APPLICANT CERTIFICATION

- 1. It is my intention to utilize my accrued leave while my application for disability retirement is pending.
- 2. I fully understand that using my leave accruals may have a direct effect on the effective date of my retirement.
- 3. I further understand the effective date of my retirement may be adjusted when the Medical Examining Board renders a decision (whether it is a favorable decision or not).
- 4. Lastly, I understand the effective date of my retirement will be adjusted to the first of the month following either the exhaustion of my leave accruals or when the Medical Examining Board renders their decision, whichever is earlier.
- 5. Under no circumstances may I receive salary and retirement income for the same period of time.
 - I acknowledge receipt of DAS LAW letter "To Employee on Leave Pending Determination of Disability Retirement Application" (reverse side of this page).

Employee Signature	Date
AGEN	NCY CERTIFICATION
The above-named employee will be paid for sending. The following is our representation he last working day of the month prior to him.	or unused accrued leave while his/her disability retirement is on of the amount of leave that this individual has accrued as of is/her application for disability retirement.
Number of sick days or hours:	day/hours
Number of vacation days or hours:	day/hours
certify that the information provided agency's responsibility to revise the cursed in the service credit and the average	herein is accurate. It is understood that it will be the rent retirement application to include any leave accruals salary.

Date

Authorized Agency Signature