



STATE OF DELAWARE  
OFFICE OF PENSIONS

PENSION CREDITABLE  
COMPENSATION  
(SCHOOL)

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): \_\_\_\_\_

Employee Months Worked: 9 10 11 12

<b>Amount of Last Regular Pay:</b>	
Regular Salary	
Overtime	
EPER Pay	
Other -	
<b>Total of Last Regular Pay:</b>	
<b>Date Disbursed:</b>	

**Amount of Lump Sum 26/22 Pay (days worked) Adjustments Paid After Termination:** (attach worksheet w/calculations)

**Total:** \_\_\_\_\_  
**Date Disbursed:** \_\_\_\_\_

**Salary Paid Due to Employee Electing 26 Pays:**

Date: \_\_\_\_\_ Amt: \_\_\_\_\_ Date: \_\_\_\_\_ Amt: \_\_\_\_\_  
Date: \_\_\_\_\_ Amt: \_\_\_\_\_ Date: \_\_\_\_\_ Amt: \_\_\_\_\_

**Amount of Paid Sick Leave:**

Number of Days Accrued \_\_\_\_\_  
Total # of Days Paid \_\_\_\_\_ x Daily Rate \_\_\_\_\_ **Total:** \_\_\_\_\_  
**Date Disbursed:** \_\_\_\_\_

**Amount of Paid Vacation Leave:**

Total # of Days Paid \_\_\_\_\_ x Daily Rate \_\_\_\_\_ **Total:** \_\_\_\_\_  
**Date Disbursed:** \_\_\_\_\_

**I CERTIFY THAT THERE ARE NO PAYROLL ADJUSTMENTS PENDING.**

\_\_\_\_\_  
AUTHORIZED SIGNATURE TITLE DATE

Print Name: \_\_\_\_\_ School District: \_\_\_\_\_