



**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: \_\_\_\_\_