ODAFF
Employee Injury Reporting Procedures

Human Resource Department
2800 N. Lincoln Blvd
Oklahoma City, OK 73105
(405)522-5771
Table of Contents & Instructions

1. Network Provider information listed by county.
2. Workers Compensation Incident Investigation Report Form
   2.1.1. Employee or Supervisor will complete, p. 1.
   2.1.2. Supervisor will complete the investigation, p. 2.
   3.1.1. Employee will complete date and sign.
   3.1.2. Risk Management Coordinator will date and sign.
   4.1.1. Employee will complete, date and sign.
   4.1.2. Supervisor will review, date and sign.
   5.1.1. Employee will complete date and sign.
7. ODAFF WC Program Leave Option Election Work Related Accident /Illness
   7.1.1. Complete and return to HR with WC package. (if you are absent from work because of WC)
8. OPERS Application for Purchase of Delinquent Service. (OPERS Enrollment ONLY) Does not apply to Pathfinder Retirement.
   8.1.1. If employee elects to purchase the delinquent service time, it is the employees’ responsibility to submit the request to HR.
9. ODOL 300 Questionnaire.
   10.1 Employee will complete.
10. Employee will forward Return to Work Status form; returned to HR after each medical visit.
   11.1 Medical provider will complete, date and sign.
   11.2 Employee forwards to Supervisor.
   11.3 Supervisor forwards to Human Resource Department.

*The claim cannot be submitted to Gallagher Bassett until HR receives the completed Workers Compensation Forms listed below; from the injured employee and supervisor.*
Table of Contents & Instructions

Return the below forms to the Human Resource Department as soon as possible and no later than 3 working days.

1. Workers Compensation Incident Investigation Report Form.
5. ODAFF Leave Option Election Work Related Accident/Illness
6. OPERS Application for Purchase of Delinquent Service
7. ODOL 300 Questionnaire.
8. Return to Work Status form; returned to HR after each medical visit

After your claim has been submitted to Gallagher Bassett you will be assigned one of the below claims adjusters within approximately 5 working days. If you have any question or concerns regarding your claim please contact your assigned adjuster.

Trent Voth 405-415-8304  Trent_Voth@gbtpa.com
Kathy Wigley 405-415-8309  Mary_Wigley@gbtpa.com
Twana Brinlee 405-415-8308  Twana_Brinlee@gbtpa.com
Michael Baxter 405-415-8307  Michael_Baxter@gbtpa.com
Elaine Howard 405-415-8311  Elaine_Howard@gbtpa.com
Bradley Morrisett 405-415-8305  Bradley_Morrisett@gbtpa.com

PeopleSoft Workers Compensation Leave Codes
WCANP – Workers Comp An Lv Hrs Pd
WCCT1  – Workers Comp Comp Time Hrs Pd
WCSKP  – Workers Comp Sick Lv Hrs Pd
WCWOH– Workers Comp Without Pay Hours

If you receive a bill in the mail, make a copy and mail original to:
Gallagher Bassett Services, Inc.
PO Box 2831
Clinton, IA 52733-2831
To Find Gallagher Bassett Managed Care Services Network Providers

Website: www.talispoint.com/gb/gbcare1

Search by:
• Address
• Zip or city/state
• Specify the types of providers, e.g. First Treatment providers, Occupational Medical Clinics, etc.
• Providers who are in our preferred Outcomes Based Network (OBN) are listed first, with a torch icon before their names.

OR
• Call the dedicated GB Info Line for WC:
  1-800-370-0594, Option 6
State of Oklahoma

WORKERS’ COMPENSATION INCIDENT INVESTIGATION REPORT

Check Box: □ INJURY  □ ILLNESS  □ NEAR MISS

Email completed form to: tnwclaims@tnwinc.com or fax to: 800-748-6159

A. EMPLOYEE INFORMATION: ALL FIELDS REQUIRED

<table>
<thead>
<tr>
<th>EMPLOYEE’S NAME</th>
<th>M/F</th>
<th>DOB</th>
<th>COMPLETE SSN</th>
<th>JOB TITLE/CLASSIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYEE ID NUMBER</th>
<th>FT</th>
<th>Temp</th>
<th>Seasonal</th>
<th>DATE OF INCIDENT</th>
<th>DATE OF HIRE</th>
<th>TIME WORK DAY BEGAN</th>
<th>TIME OF INCIDENT (AM/PM)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>AGENCY #</th>
<th>DEPT</th>
<th>OVERTIME?</th>
<th>SHIFT?</th>
<th>HAS EMPLOYEE LOST TIME FROM WORK?</th>
<th>HAS EMPLOYEE RETURNED TO WORK?</th>
</tr>
</thead>
<tbody>
<tr>
<td>040</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AVERAGE WEEKLY WAGE</th>
<th>AT THE TIME OF THE INCIDENT THE EMPLOYEE WAS:</th>
<th>performing the following task or tasks:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ on break ☐ on lunch ☐ arriving/leaving work for the day</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>

B. INCIDENT DETAILS: Is there any reason to question how this incident occurred? ☐ Yes ☐ No  Explain:

LOCATION/ADDRESS (where injury occurred):  DESCRIBE WHAT HAPPENED:

C. WAS MEDICAL TREATMENT REQUIRED? ☐ Yes ☐ No

1. If yes, what type of treatment and where was it received?
2. Is there a follow up appointment and if so, when is it?
3. Was employee put on restricted duty?
4. Can restricted duty be accommodated?

D. PART OF BODY INVOLVED (be specific: left, right, upper, lower, etc.)

E. TYPE OF INCIDENT

☐ Caught on or in ☐ Ingestion ☐ Inhalation ☐ Fall-same level ☐ Bitten
☐ Overexertion ☐ Electrical ☐ Chemical – skin ☐ Fall-different level ☐ Lifting
☐ Struck by/against ☐ Slip or Trip ☐ Explosion ☐ Heat/Cold exposure ☐ Cut
☐ Auto accident ☐ Cumulative injury ☐ Puncture ☐ Other __________

F. WITNESS TO INJURY (attach witness statement to investigation page 2)

<table>
<thead>
<tr>
<th>NAME #1:</th>
<th>PHONE #</th>
<th>NAME #2:</th>
<th>PHONE #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

G. FORM COMPLETED BY:

Print Name & Title  Phone # & Email Address  Date & Time Injury Reported to Agency

a.m./p.m.  a.m./p.m.
### H. SUPERVISOR’S INVESTIGATION OF INCIDENT

**WHAT HAPPENED?** (Be specific; include heights, weight, repetitions, dimensions, lighting etc.)

### I. WHY DID IT HAPPEN?

- **ROOT CAUSE #1:**
- **ROOT CAUSE #2:**
- **ROOT CAUSE #3:**

### J. WHAT CORRECTIVE ACTION IS BEING TAKEN TO ELIMINATE POTENTIAL FOR FURTHER INJURY OR ILLNESS?

What specifically is being done? How are we addressing root causes, behavior, hazards, training?

### K. DISCIPLINARY ACTION TAKEN: □ YES □ NO

Describe:

### L. FALL FROM DIFFERENT LEVEL INFORMATION:

- **Height:**
- **Was a ladder involved?** Describe:

### M. CAUSE OF INCIDENT – UNSAFE ACT: □ BY INJURED PERSON -or- □ BY OTHER PERSON (NAME):

- □ Failure to warn or signal
- □ Making safety devise inoperative
- □ Not observing where walking or driving
- □ Operating at unsafe speed
- □ Operating without safety device
- □ Taking unsafe position
- □ Negligence
- □ Working/reaching moving equipment
- □ Failure to shut off or lockout
- □ Moving objects too heavy
- □ Not wearing PPE
- □ Operating without authority
- □ Using unsafe tools or equipment
- □ Employee misconduct
- □ Overloading equipment or containers
- □ Wearing unsafe attire, jewelry etc.
- □ Disregard instructions
- □ Horseplay
- □ Lack of training
- □ No unsafe act
- □ Other __________________________

### N. CAUSE OF INCIDENT – UNSAFE CONDITION

- □ Hazardous arrangement
- □ Insufficient lighting
- □ Insufficient guarding
- □ Faulty machine or equipment
- □ Insufficient ventilation
- □ Poor Housekeeping
- □ Unsafe design
- □ Ergonomic deficiency
- □ Hazardous work method
- □ Poor air quality
- □ Wet/slippery/icy floor or ground
- □ Other __________________________
- □ Other __________________________
- □ Other __________________________
- □ Other __________________________

### O. CAUSE INFORMATION

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. □</td>
<td>□</td>
</tr>
<tr>
<td>2. □</td>
<td>□</td>
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<tr>
<td>3. □</td>
<td>□</td>
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<tr>
<td>4. □</td>
<td>□</td>
</tr>
<tr>
<td>5. □</td>
<td>□</td>
</tr>
<tr>
<td>6. □</td>
<td>□</td>
</tr>
</tbody>
</table>

Was employee doing his/her regularly assigned job? Explain a “no” answer below.
Did you (supervisor) provide proper instruction on how to do the job safely? Explain a “no” answer below.
Was employee doing this job as you had instructed? Explain a “no” answer below.
Was proper equipment provided? Explain a “no” answer below.
Was the employee using the equipment? Using it properly? Explain a “no” answer below.
Have you had similar incidents with this or other equipment in you area? Explain a “yes” answer below.

Additional comments from above:

### P. SAFETY INVESTIGATION AND FOLLOW-UP

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Was the investigation thorough?
Was corrective action taken?
Did the supervisor make every attempt to help eliminate the unsafe act or hazard?
Did the employee make every attempt to help eliminate the unsafe act of hazard?

Explanation and recommendations:

### Q. INVESTIGATION COMPLETED BY:

<table>
<thead>
<tr>
<th>Print Name &amp; Title</th>
<th>Phone # &amp; Email Address</th>
<th>Date Completed</th>
</tr>
</thead>
</table>

REQUIRED—may be sent in separately from page 1
State of Oklahoma  
Office of Management and Enterprise Services  
Division of Capital Assets Management  
Risk Management Department  

Personal/Bodily Injury  
Standard Liability Incident Report  
(Non-Vehicle Injury)

DCAM-RISK MGMT P.O. BOX 53364  
OKLAHOMA CITY, OKLAHOMA 73152  
TEL: 405/521-4999 (24h), FAX: 405/522-4442

Claim Form Requested?  
☐ Yes  ☐ No

Incident Date:  
Time:  

Date of Agency Notification:  

Location:

Address/Highway  
City  
State  
County

Describe Incident:

Photos of accident scene and location need to be taken.

Was Employee Aware of Incident?  
☐ Yes  ☐ No

Claimant's Information:

Claimant's Name:  
Address:  
City:  
State:  
Zip Code  

Phone:  ( )  -

Email Address:

Was the Claimant Injured?  
☐ Yes  ☐ No

Describe:

Name of Doctor or Hospital:

Agency Information

Agency Name:  
Agency #:  
Phone:  ( )  -

Type of Employment:  
☐ Full Time  ☐ Temporary  ☐ Volunteer  ☐ Contract

Employee Name:  
Job Title:  

Div. or Dept.  
Address:  
Phone:  ( )  -

Witnesses:

Name  
Address  
Phone

__________________________________  
__________________________________  
__________________________________  
__________________________________  
__________________________________  
__________________________________

DCAM/RISK MGMT – FORM 001be (07/2013)  
PAGE 1 OF 2
### Claim Number

**Slip and Fall**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the person distracted?</td>
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<tr>
<td>How did the person fall?</td>
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<tr>
<td>What part(s) of the body was injured?</td>
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<tr>
<td>Was the person a client of the place where the incident occurred?</td>
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<tr>
<td>Was the surface wet, oily, dirty, slippery, etc.?</td>
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<td></td>
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<tr>
<td>Were danger or caution signs posted?</td>
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<tr>
<td>Was there a transition in walkway surfaces, or any tripping hazards?</td>
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<tr>
<td>Was weather (rain/snow) a factor in the incident?</td>
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<tr>
<td>Was site cleanup needed? (spill, dirt, etc.)?</td>
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<tr>
<td>How long after first notice was incident cleaned up?</td>
<td></td>
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<tr>
<td>Type of footwear worn?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of material of shoe heel?</td>
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<tr>
<td>Did footwear contribute to the fall?</td>
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</tbody>
</table>

**Machinery Incidents**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was injury due to machinery?</td>
<td></td>
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</tr>
<tr>
<td>What type of machinery was involved in the incident?</td>
<td></td>
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</tr>
<tr>
<td>Policy/procedure regarding operation of machinery?</td>
<td></td>
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</tr>
<tr>
<td>Machinery last service date?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Machinery last safety inspection?</td>
<td></td>
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<tr>
<td>Were safety features in place?</td>
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</tbody>
</table>

**General Questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you speak to a witness?</td>
<td></td>
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<tr>
<td>Was assistance provided?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was any non-medical personnel called to accident site?</td>
<td></td>
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<tr>
<td>Was the incident reported to local authority?</td>
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</tbody>
</table>

*Attach additional sheet, if needed*

By signing this form you are attesting the information contained is accurate.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td></td>
<td>Risk</td>
<td></td>
</tr>
<tr>
<td>Coordinator Name Printed</td>
<td></td>
<td>Coordinator Name Printed</td>
<td></td>
</tr>
</tbody>
</table>
Incident Date ___________  Time ___________  Claim No (DCAM use only): ____________________

Employee Name ___________________________  Job Title: ___________________________

State Agency Name ___________________________  Agency Number ______

Division or Dept ___________________________  Phone ______

Address ___________________________  City ___________  State ______  Zip ______

Type of Employment:  ☐ Full Time  ☐ Temporary  ☐ Volunteer  ☐ Contract

Who Authorized This Specific Duty? ___________________________

Was employee aware of incident?  ☐ Yes  ☐ No

Please describe in detail what specific duty was being performed at the time of the incident.

________________________________________________________

Employee Signature ___________________________  Supervisor Signature ___________________________

Employee Name Printed ___________________________  Supervisor Name Printed ___________________________

Date ___________________________  Date ___________________________
To the Injured Worker:
On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 844-276-2515.

To the Pharmacist:
myMatrixx, an Express Scripts company administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 844-276-2515.

Pharmacy Processing Steps
Step 1: Enter bin number 003858
Step 2: Enter processor control WC
Step 3: Enter the group number as it appears above
Step 4: Enter the injured worker’s nine-digit ID number
Step 5: Enter the injured worker’s first and last name
Step 6: Enter the injured worker’s date of injury

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it’s important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor:
Please fill in the information requested for the injured worker.

Employee Information

First M Last
_________________________ _____________

Street Address or PO Box

City State ZIP

Employer Name

006405 State of Oklahoma
Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare Network
Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie
GALLAGHER BASSETT SERVICES, INC.
AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)

Patient Information:

__________________________________________  DOB: __________  SS#: ___________________
(Print Name of Patient)

Information to be released from:

Name of Designated Facility or Provider
__________________________________________
Address

__________________________________________  City, State, Zip Code  Phone Number

Additional facility or provider:

Name of Designated Facility or Provider
__________________________________________
Address

__________________________________________  City, State, Zip Code  Phone Number

Information to be sent to:

GALLAGHER BASSETT SERVICES, INC.
ATTN: ____________________________
Name of Designated Recipient
__________________________________________
Address

__________________________________________  City, State, Zip Code  Phone Number

Information to be released:

☐  The most recent 2 years of pertinent information (chart notes, labs, X-rays and special tests)
☐  All medical records
☐  Medical Billing
☐  Specific information (Please specify) ______

Purpose for which disclosure is being made:
Processing of an insurance claim.

Date of Loss:
Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial):
  □ Drug/Alcohol abuse /treatment & diagnosis
  □ Sexually Transmitted Disease
  □ HIV/AIDS diagnosis/treatment/ testing
  □ Mental Illness or psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: ___________________________ DATE: ____________
(Patient, Guardian*, or Authorized Representative*)
[*Please provide documents to prove authority to sign on behalf of the patient]

SHALL BE VALID FOR ONE YEAR FROM THE ABOVE DATE
PHOTOCOPY VALID AS ORIGINAL

“The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”
In accordance with Section 2e of Title 85 of the Oklahoma Statutes, an employee suffering from a work-related accident or illness may supplement his or her Workers’ Compensation Temporary Total Disability (TTD) with the use of any available sick or annual leave to the extent that he or she receives the equivalent of full wages during the absence from work.

The first three calendar days of absence will NOT be compensated by Workers’ Compensation, regardless of the leave election for that period of time. When leave is used to supplement Workers’ Compensation leave without pay, a separate warrant is prepared for that time and issued on a supplemental payroll.

**Leave Option Election**

For the First Three calendar days of absence, I elect to use:

- Annual Leave ☐
- Comp Time ☐
- Sick Leave ☐
- Leave Without Pay ☐
- Shared Leave ☐

For the remainder of my absence, I elect to use:

- **Only Leave Without Pay.** This will not supplement my TTD payments. ☐
- A combination of paid leave as indicated below. This will enable me to supplement my TTD payments. I have numbered my election(s) below in the order I wish to use them.
  - Annual leave until exhausted ______
  - Regular comp time until exhausted ______
  - Sick leave until exhausted ______
  - Comp holiday until exhausted ______
  - Shared leave, if eligible ______

**Note:** Any Person receiving temporary disability benefits from any employer or the employer’s insurance carrier, must promptly report in writing to the employer or insurance carrier, any change in a material fact, or the amount of income he or she is receiving, or any change in the employment status, occurring during the period of receipt of such benefits.

I have read and understand this from and I hereby elect the above options for leave adjustments(s) to be made during my absence. I understand that this election may be changed by submitting a new Leave Option Election – Work-related Accident/Illness form. This leave option election is effective with the pay period in which it is received.

_______________________________________________________________   ______________________
Signature of Employee                                                                                                   Date

Issued 2/28/2019
This form is to be completed only by the Retirement Coordinator of a participating employer of OPERS. Use this form to certify employment during which an employee did not participate in OPERS, but may have been eligible to do so. If you need additional space, use a separate form.

**PART 1 – MEMBER INFORMATION**

Name (First, Middle, Last) ________________________  Social Security number ________________________

Agency name ________________________  Agency number ________________________

This form will be incomplete if employment status is not indicated. Check one: ☐ permanent  ☐ temporary  ☐ seasonal

**PART 2 – DELINQUENT SERVICE INFORMATION**

Provide the member’s gross salary and number of hours worked for each period of delinquent service.

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<th>Pay period End date</th>
<th>Gross salary</th>
<th>Number of hours worked</th>
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**PART 3 – RETIREMENT COORDINATOR CERTIFICATION**

“All any person who shall knowingly make any false statement, or who shall falsify or permit to be falsified any record necessary for carrying out the intent of this act for the purpose of committing fraud, shall be guilty of a misdemeanor, and upon conviction shall be punished by a fine not exceeding Five Hundred Dollars ($500.00) or by imprisonment for not exceeding one (1) year.” 74 O.S. §924

I certify that the above employee information is correct according to the records of this participating employer.

Retirement Coordinator’s signature ________________________  Date ________________________