

WORKSHARE VERIFICATION FORM

EMPLOYEES' RETIREMENT SYSTEM OF RHODE ISLAND
50 Service Avenue, 2nd Floor
Warwick, RI 02886-1021
Office (401) 462-7600 Fax (401) 462-7691
Email: ersri@ersri.org Web Site: www.ersri.org

EMPLOYER DATA

REPORTING AGENCY	TELEPHONE NUMBER	FAX NUMBER
ADDRESS		
ADDRESS		
ADDRESS		
CITY	STATE	ZIP

EMPLOYEE DATA

SOCIAL SECURITY NUMBER				DATE OF BIRTH (mm/dd/ccyy)	
NAME	FIRST		MI		LAST
ADDRESS					
ADDRESS					
ADDRESS					
CITY		STATE		ZIP	

EMPLOYER CERTIFICATION

The above employee was a WorkShare Program participant and wishes to purchase missed salary towards retirement. Please provide ERSRI with the following information.

WorkShare Start Date	WorkShare End Date	Number of WorkShare Days	Contractual / Full Annual Salary (before WorkShare)

Actual Dates employee was out due to Workshare FROM: / / TO: / /

Returned to regular work schedule,

or Terminated, on Date: / /

OFFICIAL'S STATEMENT AND SIGNATURE

I hereby certify the above information to be true and correct based upon our official records.

SIGNATURE	DATE OF SIGNATURE (mm/dd/ccyy)
PRINT NAME	TITLE