EMPLOYEES' RETIREMENT SYSTEM OF RHODE ISLAND 50 Service Avenue
Warwick RI 02886

Warwick, RI 02886 Office (401) 462-7600, Fax (401) 462-7691 Email: ersri@ersri.org Web Site: www.ersri.org

OUT-OF-STATE TEACHING CREDIT REQUEST FORM

Instructions: Please print or type in black ink. This form must first be authorized by the member and certified by an ERSRI school official, forwarded to the out-of-state employer for certification, then forwarded to the out of state retirement system for completion. The completed form must then be returned to the Employees' Retirement System of Rhode Island. Incomplete or inaccurate forms will not be processed.

MEMBER I	NFORMATION							
SOCIAL SECURITY NUMBER					DATE OF BIRTH (mm/dd/ccyy)			
NAME	FIRST		MI		LAST			
ADDRESS								
ADDRESS								
ADDRESS								
CITY			STATE		ZIP			
MEMBER .	AUTHORIZATION							
	alse statement reg						member who knowingly ace but only to a return of	
SIGNATURE	OF MEMBER				DATE OF SIGNATURE (mm/dd/ccyy)			
ERSRI SC	HOOL OFFICIAL'S	S CERTIFICATIO	N					
CURRENT SCHOOL DISTRICT AND POSITION					CURRENT SCHOO	ND CONTRACTUAL SALARY		
I hereby ce	ertify the above sa	alary information	n to be true a	nd correct b	ased upon our of	fficial reco	ords.	
SIGNATURE OF SCHOOL OFFICIAL					DATE OF SIGNATURE (mm/dd/ccyy)			
OUT-OF-S	TATE EMPLOYER	RINFORMATION						
SCHOOL/SCHOOL DISTRICT			TELEPHONE NUMBER		FAX NUMBER		INDICATE WHETHER SCHOOL IS "N" NON-PROFIT OR "P" PROFIT:	
ADDRESS								
ADDRESS								
ADDRESS								
CITY			STATE			ZIP		

EMPLOYEE'S NAME	FIRST	«FirstName»		МІ	«Middle Initial»	LAST	«LastNan	me»			
OUT-OF-STATE	EMPLO	YER CERTIFICA	TION								
EMPLOYEE'S TITLE			NUMBER OF DAYS IN SCHOOL YEAR								
Was service render	rary basis?		□YES			□NO					
								ate whether service was ge of full-time employment.			
Period Of Employment			Number of Days Worked		Full-Time			Part-Time			
From (mm/dd/ccyy) To(mm/dd/ccyy)		To(mm/dd/ccyy)	Max(180)					(List % of Full-Time)			
Was there a forme	r Retiren	nent System?	YES □ NO								
If yes, after completing this section, please forward this form to the Retirement System or Plan in which the person was a member for completion.											
I hereby certify the	above i	nformation to be	true and correc	t ba	sed upon c	our offic	ial records	S.			
SIGNATURE					DATE OF SIGNATURE (mm/dd/ccyy)						
PRINT NAME			TITLE								
OUT-OF-STATE RE	TIREME	ENT SYSTEM OR I	PENSION PLAN	I CE	RTIFICATION	ON					
Is the member rece or plan based on thi			benefit from yo	ur s	ystem 🔲	YES		□NO			
If this member bec								ludes the service certified for nmediately.			
SIGNATURE			DATE OF SIGNATURE (mm/dd/ccyy)								
PRINT NAME			TITLE								
NAME OF RETIREME	ENT SYST	EM									

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