

**TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER  
INTER-AGENCY EMPLOYMENT VERIFICATION/TRANSFER FORM**

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

From: Texas Tech University  
Health Sciences Center (Agency #739)  
Personnel Records  
3601 4<sup>th</sup> St., STOP 8100  
Lubbock, TX 79430  
Phone # (806) 743-2865  
FAX # (806) 743-2882  
Attn: \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Re:  TRANSFER TO/FROM YOUR AGENCY  
 VERIFICATION OF PRIOR SERVICE

\_\_\_\_\_  
Last First Initial Maiden SS Number

DATES OF EMPLOYMENT (Employee indicates dates of employment were \_\_\_\_\_ to \_\_\_\_\_)

Agency Name: _____			Agency Number: _____						
FROM Month Day Year	TO Month Day Year	Position	Appointment 9 mo., 10 mo., 12 mo., etc.	% of Time (FTE)	Total State Service				
						_____ Years			
						_____ Months			

BREAKS IN SERVICE: Official Leave of Absence; LWOP, or Hourly not on payroll 30 days or more:

From \_\_\_\_\_ to \_\_\_\_\_ Reason \_\_\_\_\_  
From \_\_\_\_\_ to \_\_\_\_\_ Reason \_\_\_\_\_

**LEAVE TRANSFERRED**

**LONGEVITY**

**HAZARDOUS DUTY**

Annual leave: Hrs. ____ Min. ____	Receiving longevity pay? Yes__ No__	Receiving Hazardous Pay? Yes__ No__
Sick leave: Hrs. ____ Min. ____	Longevity paid thru: _____	Hazardous Paid Thru: _____
Leave credited thru: _____	Monthly longevity rate: _____	Monthly Hazardous Rate: _____

**RETIREMENT INFORMATION**

\_\_\_\_ Did employee retire from your Agency? Yes \_\_\_\_ No \_\_\_\_ Retirement Date \_\_\_\_\_

\_\_\_\_ Did employee retire from any public retirement system in Texas prior to employment with your agency? Yes \_\_\_\_ No \_\_\_\_

Retirement Date: \_\_\_\_\_ Agency Name \_\_\_\_\_ Agency Number \_\_\_\_\_ Retirement System: \_\_\_\_\_

\_\_\_\_ Teacher Retirement (TRS) Did employee participate prior to 9/1/96? Yes\_\_ No\_\_

\_\_\_\_ Optional Retirement (ORP) Did employee participate prior to 9/1/96? Yes\_\_ No\_\_

\_\_\_\_ Employee Retirement (ERS) Vested? Yes \_\_\_\_\_ No \_\_\_\_\_  
Did employee participate prior to 9/1/96? Yes \_\_\_\_\_ No \_\_\_\_\_

**PAYROLL INFORMATION**

Was employee eligible for Benefit Replacement Pay? Yes \_\_\_\_\_ No \_\_\_\_\_

Maximum Annual Benefit Replacement Pay Amount.....\$ \_\_\_\_\_

Calendar Year-to-Date Benefit Replacement Pay.....\$ \_\_\_\_\_

Certified: \_\_\_\_\_  
SIGNATURE TYPED NAME & TITLE OF CERTIFYING OFFICIAL DATE