

EMPLOYEES' RETIREMENT SYSTEM OF RHODE ISLAND  
40 Fountain Street, 1<sup>st</sup> Floor  
Providence, RI 02903 – 1854  
Office (401) 222-2203, Fax (401) 222-2430

## 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.**

### MEMBER INFORMATION

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

### MEMBER AUTHORIZATION

**I, the undersigned, certify that the above information is true and correct. I understand that any member who knowingly makes a false statement regarding purchase credit shall not be entitled to a retirement allowance but only to a return of contributions.**

SIGNATURE OF MEMBER

DATE OF SIGNATURE (mm/dd/ccyy)

### ERSRI SCHOOL OFFICIAL'S CERTIFICATION

CURRENT SCHOOL DISTRICT AND POSITION

CURRENT SCHOOL YEAR AND CONTRACTUAL SALARY

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

SIGNATURE OF SCHOOL OFFICIAL

DATE OF SIGNATURE (mm/dd/ccyy)

### OUT-OF-STATE EMPLOYER INFORMATION

SCHOOL/SCHOOL DISTRICT

TELEPHONE NUMBER

FAX NUMBER

INDICATE WHETHER SCHOOL IS  
"N" NON-PROFIT OR "P" PROFIT:

ADDRESS

ADDRESS

ADDRESS

CITY	STATE	ZIP
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## OUT-OF-STATE EMPLOYER CERTIFICATION

EMPLOYEE'S TITLE	NUMBER OF DAYS IN SCHOOL YEAR
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Was service rendered on a substitute or temporary basis?  YES  NO

**Report service rendered in your school/district. List each school year separately, and indicate whether service was rendered on a full-time or part-time basis. If service was part-time, please indicate percentage of full-time employment.**

Period Of Employment		Number of Days Worked Max(180)	Full-Time	Part-Time (List % of Full-Time)
From (mm/dd/ccyy)	To(mm/dd/ccyy)			

**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 salary information to be true and correct based upon our official records.**

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

## OUT-OF-STATE RETIREMENT SYSTEM OR PENSION PLAN CERTIFICATION

Is the member receiving or entitled to receive a benefit from your system or plan based on this service?  YES  NO

**If this member becomes eligible to receive a retirement benefit from your system, which includes the service certified for purchase in the Employees' Retirement System of Rhode Island, please inform this office immediately.**

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

NAME OF RETIREMENT SYSTEM