

Employee Total State Service Adjustment Form

This form is used to verify an employee's Total State Service and to request **Length of Service (LOS)** adjustments/corrections.

Instructions

All fields, if applicable, should be completed and all signatures are required prior to submitting this form to **Best Shared Services (BSS)** for review and processing. Once the form has been completed, fax or email form to **BEST Shared Services** as a ticket to the attention of the OM/PA team. You may email the form to best@ncosc.gov or fax it to 919.855.6861

Employee Total State Service Adjustment Form Header

- **Name:** Enter full name as in the HR/Payroll Integrated System.
- **Position/Title Classification:** Enter official state job title (Example = Personnel Analyst III).
- **Personnel Number:** Number assigned to the EE when hired into the HR/Payroll Integrated System.
- **Agency/Division or Facility:** Enter Division/Section, e.g. facility name.
- **Total Months:** The amount of Length of Service (LOS) the EE currently has in the system as of the date the form is filled out.
- **Total Months to be Added/Removed:** LOS that will need to be added or removed from the system (EE was not given the correct Length of Service or EE was given too much service).

Certification of Total State Service Section

Check the appropriate box and complete information if applicable.

- Please list the Month, Day and Year in the applicable box selected.
- **Department / Agency:** column should list the EE's former and current State service employer and contact information if known (please use the attached **Additional Total State Service** page if necessary).
- **Inclusive Dates:** This column should reflect dates for the employee's complete chronological work history for every different job(s) he/she has worked for a creditable service agency. Dates are to be given in month/day/year format. **This section includes the current creditable service agency.**
- **Total Months of Service:** This column is the mathematical result of calculating the Inclusive Dates start to end period.
- **LWOP:** This column should list any unpaid absence while on Leave of Absence (LOA) or any other type of unpaid leave that would affect the EE's total state service for retirement.

Employee Total State Service Adjustment Form

Please refer to OSHR's policy regarding [Total State Service](#) and [Creditable Service Employers](#) for additional information.

NOTE: The Total State Service below will be verified by the employing agency by the current Agency Human Resources Division. This form should only be completed for permanent employees.

Employee Information

Employee Name:

Personnel Number:

Position/Title Classification:

Agency/Division or Facility:

Employment

Total Months EE Currently Has in the System: _____ As of Date: _____

Total Months to Be Added or Removed in the System:

Months to be Added: _____

Or

Months to be Removed: _____

Total Months of Service After Revision _____

Certificate of Total State Service

Enter the date your current **Permanent** employment with the State of North Carolina began.

Select the appropriate box regarding **Total State Service**.

- ☐ I certify that I **Do Not** have any work experience which will qualify towards my **Total State Service**.
- ☐ I certify that I **Do** have work experience which may qualify towards my **Total State Service**.

Department/Agency (Job Title/Address/Phone Number)	Inclusive Start Date (Month/day/Year)	Inclusive End Date (Month/day/Year)	Total Months of Service	LWOP Start Date (Month/day/Year)	LWOP End Date (Month/day/Year)

***All signatures below are required for processing.**

Employee Certification

I certify that I have read the above information and have had any questions answered to my satisfaction regarding my Total State Service.

Date:	Name of Employee (Print):	Signature of Employee:
_____	_____	_____

Employer Certification

All Total State Service listed has been verified by Human Resources and service leave adjustments will be made, if necessary.

Date:	Agency HR Rep Name (Print):	Agency HR Rep Signature:
_____	_____	_____

Additional Total State Service

Department/Agency (Job Title/Address/Phone Number)	Inclusive Start Date (mm/dd/yyyy)	Inclusive End Date (mm/dd/yyyy)	Total Months of Service	LWOP Start Date (mm/dd/yyyy)	LWOP End Date (mm/dd/yyyy)