CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

FACULTY EARLY RETIREMENT PROGRAM

12 Month Request Form
SSPAR/Librarian

INSTRUCTIONS: This form is to be used by any 12 Month faculty who wishes to request participation in the Faculty Early Retirement Program (FERP) or to request a change in FERP status. (Consultation with your Supervisor and College Administrative Analyst (AA/S) is recommended).

Applicants are urged to read FAM Policy No. 625.7 (http://senate.csusb.edu/FAM/Policy/(FSD13-02)FERP.pdf) as well as Article 29 of the Unit 3 Collective Bargaining Agreement prior to completing this application (http://www.calfac.org/resource/collective-bargaining-agreement-contract-2014-2017#article-29).

Name: _____ **Department:** _____

Signature: _____ **Date:** _____

Prior to the time of the service retirement and appointment in FERP, a participant may elect to carry over up to forty-eight (48) hours of sick leave into the FERP appointment if the participant elects to reduce his/her accumulated sick leave by that amount for service retirement credit.

☐ (initial) I elect to carry over _____ sick hours (**maximum of 48**) into the FERP program.

PERIOD OF ANNUAL PARTICIPATION (select one)

☐ **6 MONTHS (Example:** Sept 1st to February 28th at .50 time-base work 6 month/160 hrs a month x 6 = 960 hrs)

☐ **12 MONTHS (Example:** Sept 1st to August 31st at .50 time base (work 12 months/80 hrs a month x 12 = 960 hrs)

☐ OTHERS: (Work schedule not to exceed 960 hours during calendar year)

FROM_____ **TO** _____
(MO/DD/YY) **(MO/DD/YY)**

Period of your FERP employment must not exceed 960 hours. During the period of the FERP employment CSU will provide the Enhanced dental plan only if the time-base is at least .5 or greater. If there is a break in the FERP employment this may affect your benefits entitlement.

CHANGE PERIOD OF PARTICIPATION/TIMEBASE

CURRENT

FROM_____ **TO** _____
(MO/DD/YY) **(MO/DD/YY)**

NEW CHANGE

FROM_____ **TO** _____
Initial **(MO/DD/YY)** **(MO/DD/YY)**

LEAVE WITHOUT PAY - For Personal Medical Reasons Only

TO _____ **FROM** _____
Initial **(MO/DD/YY)** **(MO/DD/YY)**

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AA/S Verification
Name: _____
Date: _____

Supervisor Recommendation: ◯ Recommend ◯ Do Not Recommend

(Attach additional pages if more space is needed)

Supervisor Comments:

_____

Supervisor's Signature Date

(Please forward to College Administrative Analyst)

Director/Dean Recommendation: ◯ Recommend ◯ Do Not Recommend

(Attach additional pages if more space is needed)

Director/Dean Comments:

_____

Director/Dean's Signature Date

(Please forward to Academic Affairs)

VPAA's Recommendation: ◯ Approve ◯ Do Not Approve

(Attach additional pages if more space is needed)

VPAA's Comments:

_____

Vice President's Signature Date

(Please forward to Academic Personnel)

Revised 6/2018