These forms are included only as examples for your reference and are not currently available through the CalPERS Forms & Publications Center. Although these forms were current as of the publication date of this Guide, CalPERS forms are subject to revision.

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The information provided in this publication is for your convenience and reference as a general guide only and cannot be relied upon as an authoritative source for the law, practices, or policies of CalPERS. While CalPERS tries to include only accurate, timely and complete information in its publications, summaries, guidelines and other advisory printed materials, sometimes information provided in printed materials may be or become inaccurate, untimely, incomplete, unclear or misleading. In all instances, the law then in effect, not this publication, controls the application of the Public Employees’ Retirement Law. It is the reader’s responsibility to independently verify the accuracy of the information contained in this publication before engaging in a course of action.
Employee: [employeeName]
employeeID:

[changeScript] (stateAnyScript) Please change the following effective [effectiveDateOfRequest].

<table>
<thead>
<tr>
<th>Category</th>
<th>OLD</th>
<th>NEW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(oldCategory)</td>
<td>(newCategory)</td>
</tr>
<tr>
<td>Employee Contribution Rate:</td>
<td>(oldEmpRate)</td>
<td>(newEmpRate)</td>
</tr>
<tr>
<td>Social Security:</td>
<td>(oldSSIndicator)</td>
<td>(newSSIndicator)</td>
</tr>
<tr>
<td>SB Survivor Election:</td>
<td>(oldSBIndicator)</td>
<td>(newSBIndicator)</td>
</tr>
</tbody>
</table>

If you have any questions, please visit our Web site [systemWebsite] or you may contact us toll free at [1800 CalPERS] (or 1-800-725-7377).

divisionName

[Signature][MM/YYYY]
Important: Please attach a copy of the claim showing the original designation of benefits.

DISCLAIMER OF BENEFITS

I, __________________ have been notified by, that I

(Please print)
am entitled to receive benefits in the event of the death of:

Member's First Name   Middle Initial   Last Name

I forgo the benefit of __________________ plus any Cost of Living increases and other adjustments payable for life.

I, __________________, WITH FULL UNDERSTANDING OF THE NATURE AND AMOUNT OF THE BENEFIT TO WHICH I AM ENTITLED, HEREBY FOREVER DISCLAIM ALL RIGHTS AND INTEREST I HAVE TO THIS BENEFIT IN ITS ENTIRETY.

I understand, due to my disclaimer of the above-described benefit, that it will be paid as if I were never entitled.

I understand by disclaiming my benefit, I have no right to designate any individual to whom the benefit shall be paid.

I understand that recommends I contact an attorney for legal advice prior to signing this Disclaimer of Benefits, but does not require such consultation.

I understand this Disclaimer of Benefits is irrevocable and will not be set aside for any reason, and I hereby release from any claim I have to this benefit.

I assert I have signed this document in accordance with my own free will and I have not been coerced or forced to sign this document by anyone.

I further assert that I understood the contents and effect of this document before signing it and any questions I had concerning the effect or contents of this document were fully answered by personnel prior to my signing this document.
Dear

This letter is to acknowledge receipt of your application for Service Retirement effective July 91, 2012.

If you are currently enrolled in a CalPERS basic health plan you may continue your health insurance into retirement. Please contact your personnel office to ensure your health benefit coverage is active until your retirement processing is completed.

You may be entitled to receive a disability retirement if you are unable to work because of an illness or injury. To request a service pending disability retirement, you must complete a Disability Retirement Election Application. Please note that your retirement date cannot be earlier than the day following your last day on pay status.

CalPERS will send you a letter providing the date of your first retirement check, the amount you can expect to receive, and important income tax information. This letter is usually sent after you have separated from employment but before you receive your first retirement benefit check. Changes to the benefit option election you make, beneficiary you designate, or the retirement date you request, cannot be made after you receive your first full retirement benefit check.

Retirement Type: [ ]
Last Day on Payroll: [ ]
Date of Birth: [ ]

Federal Tax: [ ]
State Tax: [ ]

CalPERS ID: [ ]
January 28, 2005

TO: (Agency name)

From: Benefit Services Division

Subject: (Member name)
(Member SSA#)

This is to advise you that an application for Service Retirement is being processed for the above member.

You will receive letter PERS-BAS-52, Notice of Placement on Retirement Roll, after the member is placed on the retirement roll. This letter will provide the employees' effective retirement date and the number of sick leave days that were included in the employee's retirement calculation.

Please provide your employee with information concerning continuation of health and dental benefits into retirement, if applicable.

Note: If the employee is eligible to continue his/her dental coverage, a new dental enrollment form must be submitted to:

CalPERS, Benefits Services Division
Attn: Warrant/Roll Support Unit #468
PO Box 942716
Sacramento, CA 94229-2716

For information regarding health and dental eligibility or enrollment processing procedures for annuitants, please refer to your Health Benefits Procedure Manual or contact Health Benefit Services Division toll free at (888) CalPERS (225-7277).

BSC-107-W

California Public Employees' Retirement System
Lincoln Plaza-400 P Street-Sacramento, CA 95814
Dear [Name],

Your Service Retirement Allowance:
Your election to receive the Option 2 has been processed.

Your retroactive warrant will be issued on June 04, 2012 and will cover the period of December 02, 2011 through May 31, 2012.

Your monthly retirement benefit is $2,241.64 based on your retirement date of December 02, 2011. This amount does not include any deduction you have authorized this system to make. Your first regular warrant will arrive on or shortly after July 01, 2012 and will cover the period of 06/01/2012 through 06/30/2012. Your future retirement warrant will be mailed to arrive shortly after the first of the month following the month to which they apply.

Beneficiary/Survivor Allowance:
Upon your death, benefits will be paid to your beneficiary in accordance with the designation indicated on your retirement election document. If you elected a benefit which requires marriage and/or birth documentation and you have not submitted these documents, please send them immediately to Benefits Services Division. If the documents are not in file at the time of your death, it may be necessary to delay payment of benefits to your beneficiary.

Income Tax Information:
The following information regarding your contributions will assist you in the determination of the taxability of your benefit.

<table>
<thead>
<tr>
<th>Contributions</th>
<th>Total Contributions and Interest</th>
<th>Interest</th>
<th>Taxed Contributions</th>
<th>Non-Taxed Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[Signature] 09/24

Page 1 of 3
Date

Employer Name
Address
City/State/Zip

CalPERS ID:

Subject

Participant CalPERS ID:

Notice of Placement on Retirement Roll:
This is to advise you that the employee named above has been placed on our 05/2012 Service Retirement Roll with an effective date of May 31, 2012 and a separation date of April 30, 2012. 0.0 days of unused sick leave have been credited to the member's account. 0.0 days of unused education leave have been credited to the member's account. The employee's separation date is the date following the employee's last day in employment status. The date can be equal to but no later than the retirement date. Please notify us immediately if separation did not occur by the date.

For information regarding employment of a retired member, please see your "Procedure Manual for Reporting to the California Public Employees' Retirement System." If any of the information above is not correct, please contact us.

If you have any questions, please visit our Web site www.calpers.ca.gov or you may contact us toll free at 888 CalPERS (or 888-225-7377).

Benefit Services Division

myCalPERS #928
Business Partner CalPERS ID:

1. Please describe special compensation listed below in detail.
2. Fax supporting MOU pages for special compensation items.
3. Identify periods covered for any lump sum payments.
4. Please fax formal salary schedule for pay rate(s).

<table>
<thead>
<tr>
<th>Service Period</th>
<th>Pay Rate Reported</th>
<th>Special Compensation Reported</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

* Please fax information within 48 hours time to the fax number above.
Application for Retired Member/Payee Survivor Benefits

Name of the Deceased Member: [Name]
Social Security Number / CalPERS ID Number: [Number]

Signature Section

Required Information

I certify under penalty of perjury under the laws of the State of California that the information provided here is correct to the best of my knowledge. You also acknowledge and agree to the following:

- I have read and understand the terms and conditions of the CalPERS Retirement Plan and the CalPERS Survivor Benefit Program.
- I understand that if there is any misrepresentation or concealment of material facts, I may be liable for any benefits paid to me that are later determined to be incorrect.
- I understand that I must provide all necessary documentation to support the request for survivor benefits.
- I understand that if there is any change in my address or telephone number, I must notify CalPERS immediately.

Name: [First Name, Middle Initial, Last Name]
Daytime Phone: [Phone Number]
Signature: [Signature]
Date (mm/dd/yyyy): [Date]
Sex: [Male/Female]

Address for Payment:
City: [City]
State: [State]
ZIP: [ZIP Code]

Address for Other Correspondences:
City: [City]
State: [State]
ZIP: [ZIP Code]

Section 1

Please fill out this form as completely as possible. The information will help us determine who is entitled to survivor benefits.

Information About the Member and Immediate Family

- Name of Executor/Administrator: [Name]
- Address: [Address]
- City: [City]
- State: [State]
- ZIP: [ZIP Code]
- Daytime Phone: [Phone Number]
- Attorney Handling Probate: [Name]
- Address: [Address]
- City: [City]
- State: [State]
- ZIP: [ZIP Code]
- Daytime Phone: [Phone Number]

Did the deceased have a will? [Yes/No/Don’t Know]

(Copy is not required unless the estate is the named beneficiary and does not require probate.)

Did the deceased leave a will? [Yes/No/Don’t Know]
Tax Withholding Election for Survivor Benefits

Section 1

Name of the Deceased
Social Security Number / CalPERS ID Number

Prorated Payment Including Any Allowance Adjustments

Federal Tax Withholding Election

☐ I do not elect to have federal tax withheld from my death benefit payment(s).
☐ I elect to have federal tax withheld based on:

Number of Exemptions
Number of Exceptions

In addition, I elect to have the following amount of federal tax withheld: $__________

Section 2

California State Tax Withholding Election

☐ I do not elect to have state tax withheld from my death benefit payments.
☐ I elect to have state tax withheld based on:

Number of Exemptions

In addition, I elect to have the following amount of state tax withheld: $__________

By signing here, I hereby make the elections checked above.

Your Signature
Social Security Number or Tax Identification Number

Date (mm/dd/yyyy)

Important: Failure to return this form will be considered an election to have taxes withheld.
California Public Employees' Retirement System

Tax Withholding Election for Survivor Benefits Including Benefits Eligible for Rollover

Name of the Decedent: ____________________________
Social Security Number: ________________________
CalPERS ID Number: ____________________________

Important: Failure to return this form will be considered an election to have taxes withheld.

Section 1
Monthly (Periodic Payments) and/or Prorated Payment

Federal Tax Withholding Election
☐ I do not elect to have federal tax withheld from my death benefit payment(s).
☐ I elect to have federal tax withheld based on: [ ] Single [ ] Married
[ ] Number of Exemptions: [ ] Number of Exemptions: 
[ ] In addition, I elect to have the following amount of federal tax withheld $________

California State Tax Withholding Election
☐ I do not elect to have state tax withheld from my death benefit payment(s).
☐ I elect to have state tax withheld based on: [ ] Single [ ] Married
[ ] Number of Exemptions: [ ] Number of Exemptions: 
[ ] In addition, I elect to have the following amount of state tax withheld $________
[ ] I elect to have the following state tax withheld: of total amount of state tax
withheld $________
[ ] I elect to have state tax withheld in the amount of 16 percent of the amount withheld for federal income
tax withholding.

Section 2
Lump Sum (Non-Periodic Payments) Option One and Temporary Annuity Payments

Federal Tax Withholding Election
☐ I do not elect to have the taxable portion of the lump sum benefit payment rolled into an Individual Retirement Account (IRA). I understand that 20 percent federal tax will be withheld.
☐ I elect to have the taxable portion of the lump sum benefit payment rolled into the following individual Retirement Account (IRA):
[ ] Name of Financial Institution: ____________________________
[ ] Plan Name: ____________________________
[ ] Account Number: ____________________________
[ ] Address of Institution: ____________________________
[ ] City: ____________________________ [ ] State: ____________________________ [ ] ZIP Code: ____________________________

California Tax Withholding Election
☐ I do not elect to have State tax withheld from my lump sum benefit payment.
☐ I elect to have State tax withheld from my lump sum benefit payment:

California law provides that non-spouses or same-sex spousal beneficiaries are subject to 30% withholding unless none was established as their relator is entitled to an "intestate IRA" pursuant to provision of RC 402(C)(1)(a).
RESOLUTION NO. 1
DETERMINATION OF A MEMBER'S DISABILITY BY THE GOVERNING BODY

Instructions:

1. If the finding is that the member is not disabled, use only this resolved clause.

2. If the finding is that the member is disabled, use this clause to state whether or not the disability was a result of injury or disease arising out of and in the course of employment.

3A. If the finding is that the member is disabled, use this clause if neither the member nor the agency seeks a determination by the Workers' Compensation Appeals Board, pursuant to G.C. section 21166.

3B. Use this clause if a petition has been or will be filed by either party.

4A. In the determination of the retirement effective date, use this clause if no dispute exists.

4B. In the determination of the retirement effective date, use this clause if the Workers' Compensation Appeals Board has disputed the retirement effective date.

5. Use this clause to state that there is, or is not, a possibility of third party liability, i.e., whether or not the member's disability was caused by negligence or an intentional act of a party other than the employer.

6. Use this clause to state whether or not the member will be paid Advanced Disability Pension Payments, and if so, how much.

7. Use this clause to state the member's primary disabling condition. For psychiatric conditions, a clause stating whether or not the member is competent to act on his/her own behalf in legally binding retirement matters must be included.
SAMPLE RESOLUTION NO. 1

RESOLUTION OF

(governing body)

(agency)

(Section 21156, Government Code)

WHEREAS, the ____________________________ (hereinafter referred to as

(name of agency)

Agency) is a contracting agency of the California Public Employees' Retirement System;

WHEREAS, the California Public Employees' Retirement Law requires that a contracting agency determine whether an employee of such agency in employment in which he/she is classified as a local safety member is disabled for purposes of the California Public Employees' Retirement Law and whether such disability is "industrial" within the meaning of such Law;

WHEREAS, an application for:

(disability/industrial disability retirement)/(reinstatement from disability retirement)

of ____________________________ employed by the Agency in the position of ____________________________ has been filed with the California Public Employees' Retirement System; and

WHEREAS, the ____________________________ has reviewed the medical and

(name of governing body)

other evidence relevant to such alleged disability;

NOW, THEREFORE, BE IT RESOLVED:

That the ____________________________ find and determine and it does hereby

(name of government body)

find and determine that ____________________________ (member's name) (is not)

incapacitated within the meaning of the California Public Employees' Retirement Law for performance of his/her duties in the position of ____________________________, and

(job title)
SAMPLE RESOLUTION NO. 1 (continued)

(2) BE IT FURTHER RESOLVED THAT THE ____________ (name of governing body)
find and determine and it does hereby find and determine that such disability ____________, a result of injury or
(is) / (is not) disease arising out of and in the course of employment.

(3A) Neither said ____________ nor the agency ____________ has
(member's name) (name of agency)
( ) applied to the Workers' Compensation Appeals Board for a determination pursuant to G.C. section 21188
whether such disability is industrial.

OR

(3B) BE IT FURTHER RESOLVED THAT A PETITION ____________
( ) (will be filed) / (has been filed)
with the Workers' Compensation Appeals Board for a determination pursuant to Section 21188, Government
Code; and a copy of such determination ____________: and
( ) (is attached) / (will be provided when rendered)

(4A) BE IT FURTHER RESOLVED that the member was, or will be, separated from his/her employment in
the position of ____________, after expiration of his/her rights under Section 21164 Government
Code, effective ____________, and that no dispute as to the expiration of such leave rights is
(date)
pending. His/Her last day on pay status is ____________.

(date)

OR

(4B) BE IT FURTHER RESOLVED that the member was separated from his employment in the position of
__________, effective ____________, the date
__________,
upon which the condition causing his/her disability became permanent and stationary as determined by the
(date)
Workers' Compensation Appeals Board in the attached finding. His/Her last day on pay status is ____________.

(date)

(5) There ____________ a possibility of third party liability.
(is) / (is not)

(6) Advanced Disability Pension Payments ____________ be made. (If payments will be made,
(will) / (will not)
provide amount and frequency.) The payments will be made ____________ in the amount of
(amount)
__________, beginning ____________, (bi-weekly, monthly, etc.)

(7) The primary disabling condition is ____________, (If condition is psychological, add the following.) The member ____________ competent to act on his/her own behalf in legally binding
(is le) retirement matters.
SAMPLE RESOLUTION NO. 2
DETERMINATION OF DISABILITY BY THE OFFICIAL DELEGATE

This Resolution is made by an Official Delegate appointed by the Governing Body. The Governing Body delegates the authority to determine the disability with a written "Delegation of Authority" (Resolution No. 3). A copy of the "Delegation of Authority" (Resolution No. 3) should be attached to the Determination of Disability (Resolution No. 2)

Instructions:
1. If the finding is that the member is not disabled, use only this resolved clause.

2A. If the finding is that the member is disabled, use this clause to state whether or not the disability was the result of injury or disease arising out of and in the course of employment.

2B. If the finding is that the member is disabled, use this clause if a petition has been or will be filed by either party.

3A. In the determination of the retirement effective date, use this clause if no dispute exists.

3B. In the determination of the retirement effective date, use this clause if the Workers' Compensation Appeals Board has disputed the retirement effective date.

4. Use this clause to state that there is, or is not, a possibility of third party liability; i.e., whether or not the member's disability was caused by negligence or an intentional act of a party other than the employer.

5. Use this clause to state whether or not the member will be paid Advanced Disability Pension Payments, and if so, how much.

6. Use this clause to state the member's primary disabling condition. For psychiatric conditions, a clause stating whether or not the member is competent to act on his/her own behalf in legally binding retirement matters must be included.
SAMPLE RESOLUTION NO. 2

(1) Pursuant to the authority delegated to me by action of________________________ (governing body)
of________________________ (name of agency)
dated________________________, under Section 21173, Government Code, and after review of
medical and other evidence relevant thereto, I hereby determine that________________________ (member’s name)
a local safety member of the California Public Employees’ Retirement System, employed by the Agency________________________
(is) (is not)
inincapacitated within the meaning of the California Public Employees’ Retirement Law for performance of
his/her duties in the position of________________________
(is) (is not)
and

(2A) Pursuant to such authority I also determine that such incapacity________________________ a result of injury or
disease arising out of and in the course of his/her employment as a local safety member. I certify that neither
the Agency nor the member has filed a petition for determination under G.C. section 21189, to be made by
the Workers’ Compensation Appeals Board.

OR

(2B) A petition for determination under G.C. section 21189 whether such disability is the result of injury or
disease arising out of and in the course of his/her employment by the Agency, in which he/she was a local
safety member, has been filed with the Workers’ Compensation Appeals Board. A certified copy
of such a determination________________________ (is attached) (will be provided when rendered).

(3A) I hereby certify that the member was separated from his/her employment in the position of
________________________
(is) (is not)
job title
Section 21194. Government Code, effective________________________ and that no dispute as to the
expiration of such leave rights is pending. His/Her last day on pay status is________________________
(date)

(date)
SAMPLE RESOLUTION NO. 2 (continued)

(38) I hereby certify that the member was separated from his/her employment in the position of 

______________________________

(job title)

effective ______________________ the day

_________________________

(date)

upon which the condition causing his/her disability became permanent and stationary as determined by the

Workers' Compensation Appeals Board in the attached finding.

His/Her last day on pay status is ______________________.

_________________________

(date)

(4) There __________ a possibility of third party liability.

(5) Advanced Disability Pension Payments __________ be made. The payments will be

( will / will not)

made __________________ in the amount of $ __________________ beginning __________________.

(bi-weekly, monthly, etc.)

(amount)

(date)

(6) The primary disabling condition is __________________________.

(condition)

(If condition is psychological, add the following:)

The member __________ competent to act on his/her own behalf in legally binding retirement matters.

(is) (is not)
SAMPLE RESOLUTION NO. 3 – DELEGATION OF AUTHORITY

RESOLUTION OF ____________________________

(name of governing body)

______________________________

(name of agency)

WHEREAS, the ____________________________ (herein referred to as Agency)

(name of agency)

is a contracting agency of the California Public Employees’ Retirement System;

WHEREAS, the Public Employees’ Retirement Law requires that a contracting agency determine whether an employee of such agency in employment in which he/she is classified as a local safety member is disabled for purposes of the Public Employees’ Retirement Law and whether such disability is “industrial” within the meaning of such Law:

WHEREAS, ____________________________ has determined upon legal

(name of governing body)

advice that it may delegate authority under Government Code Section 21173 to make such determinations to the incumbent of the office/position of ____________________________

(title)

NOW, THEREFORE, BE IT RESOLVED:

That the ____________________________ delegate and it does hereby delegate

(name of governing body)

to the incumbent of the office/position of ____________________________ authority to make

(title)

applications on behalf of the Agency pursuant to Government Code Section 21152 (c) for disability retirement of all employees and to initiate requests for reinstatement of such employees who are retired for disability;

BE IT FURTHER RESOLVED that ____________________________ delegate and it

(name of governing body)

does hereby delegate to the incumbent of the office/position of ____________________________

(title)

authority to make determinations of disability on behalf of the Agency under Government Code Section 21156 and whether such disability is industrial and to certify such determinations and all other necessary information to the California Public Employees’ Retirement System.
SAMPLE APA PROCEDURAL RESOLUTION

RESOLUTION NO.

RESOLUTION OF THE CITY COUNCIL OF THE CITY OF

ESTABLISHING A PROCEDURE FOR INDUSTRIAL DISABILITY RETIREMENT
DETERMINATIONS OF LOCAL SAFETY OFFICER EMPLOYEES OF THE PUBLIC
EMPLOYEES' RETIREMENT SYSTEM

BE IT HEREBY RESOLVED by the City Council of the City of ___________________ that following the filing of an application for industrial disability retirement by a local Safety Officer under the California Public Employees' Retirement System the following procedures shall be employed:

1. An initial determination will be made by the City upon medical and other available evidence offered by either the applicant or the City to determine whether the applicant is incapacitated from the performance of duty. The determination shall be made within six months of the date of the receipt by the City from CalPERS unless this time requirement is waived in writing by the applicant. Said determination shall be made by (employer or other person such as risk manager, personnel director, etc.) designated by the (City Manager, City Council, Mayor, etc.):

A. If it is determined by the City that the applicant is incapacitated, and the incapacity is industrial, the city manager (or appropriate authority) will so certify to CalPERS.

B. If it is determined that the applicant is incapacitated but that the cause of incapacity is nonindustrial, the city manager (or appropriate authority) will so certify to CalPERS.

C. If it is determined that the applicant is incapacitated, but the applicant contends that the cause of disability is industrial, the applicant may petition the Workers' Compensation Appeals Board (WCAB) for a Finding of Fact determining causation. If the WCAB determines the cause of incapacity to be industrial, or nonindustrial, the City will so certify to CalPERS.

D. If the City determines that the applicant is not incapacitated from the performance of duty, it shall notify the applicant and CalPERS of this determination. The City shall notify the applicant by certified mail (return receipt requested) or by personal service of his/her right to appeal their decision and request a hearing within thirty calendar days of the notice.

2. If the applicant requests a hearing, the hearing shall be held in conformity with the Administrative Procedures Act. When an applicant requests a hearing, the City shall notify CalPERS. The City will also notify the Office of Administrative Hearings and will request a hearing date and a prehearing conference with an Administrative Law Judge. The applicant will be informed that the hearing will be held at the time and place designated by the Office of Administrative Hearings which shall set a hearing date and prehearing conference.
SAMPLE APA PROCEDURAL RESOLUTION (continued)

The hearing shall be conducted before the (city manager, city council, personnel board, other designated fact finder, etc., as designated by ordinance) with the Administrative Law Judge acting as the presiding officer.

An administrative record shall be generated at the hearing pursuant to the Administrative Procedures Act. All testimony shall be recorded by a Certified Shorthand Reporter.

Following the hearing a decision and findings of fact will be made by (same as above, i.e., city manager, city council, personnel board, other designated fact finder, etc.). The decision and findings will be served on the applicant by certified mail and CalPERS will be notified.

OR

The hearing shall be conducted before the Administrative Law Judge alone.

An Administrative record shall be generated at the hearing pursuant to the Administrative Procedures Act. All testimony shall be recorded by a Certified Shorthand Reporter.

Following the hearing the Administrative Law Judge (ALJ) prepares a Proposed Decision. The decision will include a determination of issues, findings and summary of facts. The Proposed Decision will be reviewed by (same as above, i.e., city manager, city council, personnel board, other designated fact finder, etc.). The decision will be adopted by the city as its decision; or the city will reject the decision and make its own decision without hearing additional evidence; or the city will reject the ALJ decision based on additional evidence (additional hearing with ALJ to hear evidence). The decision and findings will be served on the applicant by certified mail and CalPERS will be notified. If applicant is found to be incapacitated the city shall so certify to CalPERS. If applicant is found not to be incapacitated the applicant will be further advised that he or she has thirty calendar days to seek judicial review. Such review is by means of filing a Petition for Writ of Mandate, CalPERS will be notified.

If applicant is found to be incapacitated the city shall so certify to CalPERS. If applicant is found not to be incapacitated the applicant will be further advised that he or she has thirty calendar days to seek judicial review. Such review is by means of filing a Petition for Writ of Mandate in the Superior Court of _________ County.

Upon receipt of notice that applicant has filed a Petition for Writ of Mandate in the Superior Court of _________ County, or upon expiration of thirty calendar days where applicant has not filed a Petition for Writ of Mandate, CalPERS will be notified.

Upon receipt of Writ of Mandate in the Superior Court of _________ CalPERS will be notified.