# Employer's Certification of Job Requirements

*Form DSBL 2 – Revised 12/1/2013*

*Please print or type in black ink. A supervisor with first-hand knowledge of the job requirements must complete this form and attach a copy of the official job description. Mail or fax completed form(s) to PERS. See bottom of form for contact information.*

## ❶ Member Information

First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Position Held: _____

Employment Status: ☐ Leave with Pay ☐ Leave without Pay ☐ Still Working ☐ Terminated *If terminated, list reason below.**

* Reason: ☐ Voluntary/Resignation ☐ Poor Performance Related to Medical Condition ☐ Other:_____

Comments:_____

Number of Days Absent Due to Alleged Disability during 12 Months Preceding Termination, Leave of Absence, or Application for Disability: _____

Official Position Dates: Start *mm/dd/ccyy:* _____ Last Day Worked Due to Alleged Disability *mm/dd/ccyy:*_____

## ❷ Job Requirements

Is the employee allowed to move from sitting to standing and standing to sitting? ..... ☐ Yes ☐ No

If yes, how often?_____

Can the employee vary his or her work schedule as often as needed? ..... ☐ Yes ☐ No

In your opinion, can the employee perform his or her job? ..... ☐ Yes ☐ No

If no, list specific job duties and performance expectations impaired by the employee's alleged disability:_____

_____

_____

Does the employee appear to be motivated toward continuing current employment? ..... ☐ Yes ☐ No

Has the employee been offered another job within your agency or any other agency covered by PERS without a material reduction in compensation or change in location of employment? ..... ☐ Yes ☐ No

If yes, describe job and duties:_____

_____

_____

Describe any accommodations, offered or provided the employee to allow him or her to continue gainful employment with your agency: _____

_____

_____

## ❸ Employer Certification

I understand that any person who makes a false statement or shall falsify or permit to be falsified any record of a retirement plan administered by PERS in an attempt to defraud the plan may be subject to criminal prosecution. With that understanding, I certify the above statements and information are correct to the best of my knowledge and that the below-listed employer has complied with all applicable provisions of the Americans with Disabilities Act, including but not limited to, provisions to make reasonable accommodations to allow this employee to remain on the job.

Employer Name: _____ Employer No.:_____

Employer's Mailing Address: _____ City:_____ State:_____ Zip:_____

Employer Representative's Name:_____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

Employer Representative's Signature:_____ Date *mm/dd/ccyy*: _____

Public Employees' Retirement System of Mississippi
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