



STATE OF CONNECTICUT
 TEACHERS' RETIREMENT BOARD
 765 ASYLUM AVENUE HARTFORD, CT 06105-2822
 Toll free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb
 "An Affirmative Action/Equal Opportunity Employer"

SPECIAL TEACHING SERVICE

<p>American School at Hartford for the Deaf 139 North Main ST West Hartford CT 06107</p>	<p>Connecticut Institute for the Blind 120 Holcomb ST Hartford CT 06112-1529</p>	<p>Newington Children's Hospital 1 Park ST, New Haven CT 06504 or CT Children's Medical Center 282 Washington ST, Hartford CT 06106</p>
--	--	---

Section A: (To be completed by the TRB member)

Member Name: _____ SS#: _____

Members Current Address: _____
 Street Address, Town, State and Zip code

Place of Employment: American School at Hartford for the Deaf CT Institute for the Blind
 Newington Children's Hospital CT Children's Medical Center

Members Signature: _____ Date: _____ Email: _____

Section B: (To be completed by the employer)

Position held by the member named in Section A. _____

Did this position require certification by the CT State Department of Education? Yes No

Did the individual hold the appropriate State Department of Education certificate? Yes No

Was the member eligible for participation in an employer retirement plan? Yes No

Date Began Teaching	Date Ended Teaching	Full-time	Part-time	Percentage of Part-time

I hereby certify that the information which has been provided has been extracted from official payroll records or substantiating documents.

Name of Attesting Official: _____ Title: _____

Signature: _____ Date: _____ Fax #: _____

Telephone #: _____ Email: _____

Please forward this form (Pages 1 and 2) to the retirement system that covered this individual's employment.

SPECIAL TEACHING SERVICE (Page 2)

The member listed in Section A: _____ has requested additional credit for service with the CT Teachers' Retirement System. In order to determine if the member is eligible to receive additional credit, we need the following information. If you have any questions regarding this form, please contact our office.

Section C: (To be completed by the Retirement System covering the employment in Section B)

Name and Title of the person completing this section: _____

Telephone: _____ Fax #: _____ Email: _____

Signature: _____ Date: _____

1. Was the individual listed in Section A of this form a member of your retirement plan? Yes No
2. Was this plan contributory or non-contributory for the member?
3. Was membership in your retirement system mandatory or optional?
4. Is the member eligible for a pension benefit from your system now or in the future? Yes No
5. If a contributory plan, have the member's funds been withdrawn in full? Yes No

After completion, please forward this form (Pages 1 and 2) to:

**CT TEACHERS' RETIREMENT SYSTEM
765 ASYLUM AVENUE
HARTFORD CT 06105-2822**