HCM-52
Longevity Certification Form

SECTION 1 – Current Service	
Employee Name:	Employee ID:
Agency Name:	Agency Number:
☐ Full Time ☐ Part Time ☐ Variable Hour Appointment (Temporary/Seasonal)	Agency Start Date:

SECTION 2 – Prior State Service

Most recent start date with the State:

☐ No prior State Service (Do not complete the section below)

Agency	Start Date	End Date	Full Time (FT) / Part Time (PT)	Creditable Service (Agency Use Only)
			◯ FT ◯ PT	☐
			◯ FT ◯ PT	☐
			◯ FT ◯ PT	☐
			◯ FT ◯ PT	☐
			◯ FT ◯ PT	☐
			◯ FT ◯ PT	☐
			◯ FT ◯ PT	☐
			◯ FT ◯ PT	☐

Section 3 – Employee Certification

I hereby certify that the information provided on this form is correct to the best of my knowledge.

Employee: Date:

Section 4 – Longevity Calculation (Agency Use Only – Refer to longevity Guide for assistance with completing this section.)

Total Prior Cumulative Service	
Adjustment for LWOP	
Longevity Anniversary Date	
Date of next longevity Payment	

Agency Reviewer

Name and Title:_____ Signature :_____ Date:_____