ETA-935

(STATE AGENCY IDENTIFICATION)
CLAIMANT'S AFFIDAVIT OF FEDERAL CIVILIAN SERVICE, WAGES AND REASON FOR SEPARATION, ETA-935

1. State Agency Address:	2. Claimant's Name and Mailing Address:		
3. Local Office/Call Center ID:	4. Date of Request:	5. Effective Date of Claim:	6. Separation Date
7. Federal Agency Name and Address:			8. Social Security Number

Instructions: Complete and Return Immediately

9. Affidavit of Federal Wage and Separation Information/Documentary Evidence

a. Enter the location of your Official Duty Station: (City, State)

b. Enter your wages with the above named employer below. Show wages by quarter starting with the wages that you earned after (base period begin date) up to the date you separated from this employer. Under Documentary Evidence, enter the source of the information provided and attach a copy. If additional space is needed to explain reason for separation, attach your signed explanation.

Quarter Ending	Year	Gross Wages	Documentary Evidence

c. Severance Pay. Did you receive or are you entitled to receive severance pay provided by Federal law or agency employee agreement?
___ Yes____No If "Yes" complete the following information: Total Entitlement: $________________.

Severance Pay Period Begin date:_/_/ Ending Date:_/_/

d. Pension: Are you entitled to receive a pension from any branch of the Federal Government?____Yes____No

Enter Gross Monthly Pension $________________.

e. Reason for Separation:

I, the claimant, understand that penalties are provided by law for an individual making false statements to obtain benefits and that determinations based on an affidavit are not final: that determinations are subject to correction upon receipt of wage and separation information from the Federal agency, that benefit payments made as a result of such determination may have to be adjusted on the basis of information from the Federal agency, and that any amount overpaid will have to be repaid or offset against future benefits. I, the claimant, swear or affirm, that the above statements, to the best of my knowledge, are true and correct.

10. Signature of Claimant: ____________________________________ Date:_____/_____/______

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OMB No.: 1205-0179 **OMB Expiration Date:** XX/XX/XXXX **Estimated Average Response Time:** 4 Minutes

O M B Burden Statement: These reporting instructions have been approved under the Paperwork reduction Act of 1995. Persons are not required to respond to this collection of information unless it displays a valid OMB control number. Public reporting burden for this collection of information includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Submission is required to obtain or retain benefits under SSA 303(a)(6). Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workforce Security, Room S-4231, 200 Constitution Ave., NW, Washington, DC, 20210.