

DUPLICATE WAGE AND TAX STATEMENT REQUEST

STD. 436 (REV. 9-97)

**TO: STATE CONTROLLER'S OFFICE
PERSONNEL/PAYROLL SERVICES DIVISION
ATTN: ADMINISTRATIVE SUPPORT UNIT
P. O. BOX 942850
SACRAMENTO, CA 94250-5878**

This form must be filled out in its entirety. Include a processing fee for EACH TAX YEAR requested.

FOR SCO USE ONLY	
DATE RECEIVED	DATE WORKED
CHECK NUMBER	CHECK AMOUNT
PAYROLL DEDUCTION	
AGENCY COLLECTION	
PICK UP DATE	MAILING DATE
INITIALS	

SOCIAL SECURITY NUMBER

NAME

TAX YEAR(S) REQUESTED *(Available only for 4 prior tax years)*

YEAR(S)					
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DUPLICATE WAGE AND TAX STATEMENT SHOULD BE MAILED TO *(Check one)*

EMPLOYEE ADDRESS DEPARTMENT ADDRESS

W-2 MAILING ADDRESS *(Please print)*

EMPLOYEE

DEPARTMENT NAME / ATTENTION:

NUMBER AND STREET

DAYTIME TELEPHONE NUMBER *(Include Area Code)*
()

CITY

STATE

ZIP CODE

CALL FOR PICK UP

NAME

EMPLOYEE AGENCY

DAYTIME TELEPHONE NUMBER *(Include Area Code)*
()

FOR SCO USE ONLY
DATE CALLED

BILLING METHOD *(Include processing fee for each tax year requested)*

PAYMENT ENCLOSED \$ _____ Check/money order number _____

PAYROLL DEDUCTION \$ _____ *(Employee's signature is required to authorize payroll deduction. Submit original and one copy.)*

DEPARTMENTAL BILLING \$ _____ *(Personnel Assistant's signature is required to authorize departmental billing.)*

ENTER AGENCY NAME

ENTER AGENCY CODE

AUTHORIZING SIGNATURE *(Employee or Department)*

PRINTED NAME

SIGNATURE

DATE SIGNED