MONTHLY STATE DISABILITY INSURANCE (SDI)

Payroll Deduction Statement

Employer Name: _____

Tax ID / FEIN: _____

State Employer ID: _____

Address: _____

Employee Name: _____

Employee SSN: _____

Employee ID: _____

Pay Period Ending: _____

DESCRIPTION	RATE (%)	SUBJECT WAGES	AMOUNT WITHHELD
Gross Monthly Wages			
State Disability Insurance (SDI)			
Paid Family Leave (PFL) *if applicable			
Total SDI/PFL Deductions			

_____

Prepared By (Payroll Officer Signature)

_____

Date

_____

Authorized Representative Signature

_____

Date