



BILINGUAL COMPENSATION REQUEST

Level I (Verbal)

Initiate

Promotion

Position # Change

Language Required			Effective Date
Emp ID	Rcd No.	Last Name, First Name	
Address, City, State, Zip Code			
Home Telephone		Business/Message Telephone	
Position No.	Position Type		
	Regular	Recurrent	Extra-Help Contract
Union Code	Job Code	Job Code Title	
Company	Department		Dept ID #
Department Contact (Print Name and Title)		Mail Code	Telephone

Note: Certain departments require assessment through an oral examination

The appointing authority's signature below certifies the above-named employee has satisfactorily performed bilingual verbal translation in this department.

Appointing Authority or Designee Signature	Telephone	Date
Payroll Specialist (Print & Sign)		Telephone

Office Use Only

EMPLOYMENT DIVISION CERTIFICATION

Approved	Denied	Comments:	
Oral Test Date	Pass	Fail	Billed Date:
Human Resource Signature:			Date:
Earnings Code:	Action: Pay Rate Change	Reason: Assign Additional Pay	

This document/form incorporates use of e-signatures in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

Keyed By	Date
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DISTRIBUTION: Email: Bilingual-Requests@hr.sbcounty.gov