



BILINGUAL COMPENSATION REQUEST EXEMPT

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.	Job Code	Job Code Title	
Company	Department		
Department Contact (Print Name and Title)		Mail Code	Telephone

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:		
Date Previously Tested:		Type: Oral	Written	Technical
Written Test Date:		Pass	Fail	
Billed Date:		Billed Date:	Billed Date:	
Human Resource Signature:			Date:	
Earnings Code: BL7 – Exempt		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

DISTRIBUTION: Email: Bilingual-Requests@hr.sbccounty.gov