



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		Dept ID #
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
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DISTRIBUTION: Email: Bilingual-Requests@hr.sbcounty.gov