



Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

PAYROLL ADJUSTMENTS APPROVAL REQUEST FOR SPECIAL DISTRICTS (More than 13 Pay Periods Prior)

Must print in Black or Blue ink ONLY

Employee ID	Rcd No.	Last Name, First Name		
Job Code	Job Code Title	Amount of Retro Pay	For Pay Periods	
			From:	To:

Explain in detail why the retroactive pay is being requested:

Payroll Specialist Name (Print and Sign)	Department
Telephone	Date

Office Use Only

HUMAN RESOURCES BUSINESS PARTNER REVIEW

Approved	Human Resources Business Partner Signature	Date
Denied		
Comments:		

DIRECTOR OF HUMAN RESOURCES OR DESIGNEE

Approved	Director of Human Resources or Designee Signature	Date
Denied		

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

DISTRIBUTION: Original – Central Payroll (0032)