



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

PAYROLL ADJUSTMENTS APPROVAL REQUEST

(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:

Large empty box for explanation of retroactive pay request.

Payroll Specialist Name (Print and Sign)	Department
Telephone	Date

Office Use Only

HUMAN RESOURCES BUSINESS PARTNER REVIEW

<input type="checkbox"/> Approved	Human Resources Business Partner Signature	Date
<input type="checkbox"/> Denied		

Comments:

Large empty box for comments.

DIRECTOR OF HUMAN RESOURCES OR DESIGNEE

<input type="checkbox"/> Approved	Director of Human Resources or Designee Signature	Date
<input type="checkbox"/> Denied		

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

DISTRIBUTION: Original – Central Payroll (0032)

Rev. 12/20/2024

(Payroll Adjustments Approval Request)