

Request for Establishment of a voluntary Time-Bank for Illness or Injury



FROM DEPARTMENT: DEPT CONTACT: EMPLOYEE SECTION I	TO: VOLUNTARY TIME-BANK ADMINISTRATOR, HUMAN RESOURCES DEPARTMENT		
I	FROM DEPARTMENT: DEPT CONTACT:		
AND AUTHORIZE DISTRIBUTION OF MY REQUEST ON A: COUNTY-WIDE, DEPARTMENT-WIDE, OR DIRECT TRANSFER BASIS FURTHERMORE, LUNDERSTANDING THAY APPLICATION FOR A VOLUNTARY TIME-BANK DOES NOT RELEASE ME OF MY OBLIGATION TO SEEK AND OBTAIN AN APPROVED LEAVE OF ABSENCE IN ACCORDANCE WITH THE LANGUAGE SET FORTH IN THE GOVERNING MEMORANDUM OF UNDERSTANDING OR RESOLUTION FOR EXEMPT MANAGEMENT, MANAGEMENT, CONFIDENTIAL, AND OTHER UNREPRESENTED EMPLOYEES.	Employee Section		
To SEEK AND OBTAIN AN APPROVED LEAVE OF ABSENCE IN ACCORDANCE WITH THE LANGUAGE SET FORTH IN THE GOVERNING MEMORANDUM OF UNDERSTANDING OR RESOLUTION FOR EXEMPT MANAGEMENT, MANAGEMENT, CONFIDENTIAL, AND OTHER UNREPRESENTED EMPLOYEES.	AND AUTHORIZE DISTRIBUTION OF MY REQUEST ON A: COUNTY-WIDE , DEPARTMENT-WIDE , OR DIRECT TRANSFER BASIS .		
DEPARTMENT SECTION In accordance with the County of Riverside's Voluntary Time-Bank Program, the Agency/Department Head identified below requests the establishment of a Time-Bank for the following employee: Employee ID No.:	TO SEEK AND OBTAIN AN APPROVED LEAVE OF ABSENCE IN ACCORDANCE WITH THE LANGUAGE SET FORTH IN THE GOVERNING MEMORANDUM OF UNDERSTANDING OR RESOLUTION FOR EXEMPT MANAGEMENT, MANAGEMENT, CONFIDENTIAL, AND OTHER		
DEPARTMENT SECTION In accordance with the County of Riverside's Voluntary Time-Bank Program, the Agency/Department Head identified below requests the establishment of a Time-Bank for the following employee: Employee ID No.:		/ /	
In accordance with the County of Riverside's Voluntary Time-Bank Program, the Agency/Department Head identified below requests the establishment of a Time-Bank for the following employee: EMPLOYEE NAME:		ate Signed	
JOB TITLE:	In accordance with the County of Riverside's Voluntary Time-Bank Program, the Agency/Department Head identified		
JOB TITLE:			
ESTIMATED LENGTH OF ABSENCE: / / / APPROXIMATE DATE OF RETURN TO WORK: / / • ANTICIPATED DATE EMPLOYEE WILL EXHAUST ALL LEAVE BALANCES: / / • HAS EMPLOYEE BEEN PLACED ON LEAVE PURSUANT TO THE FEDERAL FAMILY AND // / MEDICAL LEAVE ACT (FMLA) AND/OR THE CALIFORNIA FAMILY RIGHTS ACTS (CFRA)? YES NO • HAS EMPLOYEE APPLIED FOR WORKERS' COMPENSATION? YES NO • HAS EMPLOYEE APPLIED FOR WORKERS' COMPENSATION BEEN RENDERED? YES NO • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES NO • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES NO • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES NO • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES NO • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES NO • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES NO Describe conditions surrounding the request. Attach additional sheet if needed. Return to: Voluntary Time-Bank Administrator, Mail Stop #1150. // / Date IRR DEPARTMENT IRR DEPARTMENT IRR DEPARTMENT // / Date Instructions:			
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MEDICAL LEAVE ACT (FMLA) AND/OR THE CALIFORNIA FAMILY RIGHTS ACTS (CFRA)? YES No • HAS EMPLOYEE APPLIED FOR WORKERS' COMPENSATION? YES No • IF SO, HAS A WORKERS' COMPENSATION DETERMINATION BEEN RENDERED? YES No • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES No • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES No • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES No • Describe conditions surrounding the request. Attach additional sheet if needed. Return to: Voluntary Time-Bank Administrator, Mail Stop #1150.	 ANTICIPATED DATE EMPLOYEE WILL EXHAUST ALL LEAVE BALANCES: 	_/ /	
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• IF SO, HAS A WORKERS' COMPENSATION DETERMINATION BEEN RENDERED? YES NO • HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES NO Describe conditions surrounding the request. Attach additional sheet if needed. Return to: Voluntary Time-Bank Administrator, Mail Stop #1150. ///	Medical Leave Act (FMLA) and/or the California Family Rights Acts (CFRA)?	Yes 🗌 No 🗌	
HAS EMPLOYEE APPLIED FOR SHORT-TERM OR LONG-TERM DISABILITY? YES NO REASON FOR REQUEST Describe conditions surrounding the request. Attach additional sheet if needed. Return to: Voluntary Time-Bank Administrator, Mail Stop #1150. Agency/Department Head Signature IMR DEPARTMENT HR DEPARTMENT DETERMINATION: REQUEST IS APPROVED DENIED Instructions: /	HAS EMPLOYEE APPLIED FOR WORKERS' COMPENSATION?	Yes 🗌 No 🗌	
REASON FOR REQUEST Describe conditions surrounding the request. Attach additional sheet if needed. Return to: Voluntary Time-Bank Administrator, Mail Stop #1150.	IF SO, HAS A WORKERS' COMPENSATION DETERMINATION BEEN RENDERED?	Yes 🗌 No 🗌	
Describe conditions surrounding the request. Attach additional sheet if needed. Return to: Voluntary Time-Bank Administrator, Mail Stop #1150. Agency/Department Head Signature / /	Has employee applied for Short-Term or Long-Term Disability?	Yes 🗌 No 🗌	
IR DEPARTMENT HR DEPARTMENT HR DEPARTMENT DETERMINATION: Request is Approved Denied Instructions: ////	Describe conditions surrounding the request. Attach additional sheet if needed. Return to: Voluntary Time-Bank		
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HR DEPARTMENT DETERMINATION: REQUEST IS APPROVED DENIED Instructions:	Agency/Department Head SignatureDepartment	ate	
HR DEPARTMENT DETERMINATION: REQUEST IS APPROVED DENIED Instructions:	HR DEPARTMENT		
Instructions:			
Voluntary Time-Bank Administrator / /	Instructions:		
Voluntary Time-Bank Administrator Date		/ /	
	Voluntary Time-Bank Administrator	Date	

Réverside	Voluntary Time-Bank Physician Statement	
EMPLOYEE NAME:		ARE THE
EMPLOYEE NAME:	(Please Print)DATE OF BIRTH:	
	(Physician)	
MY APPLICATION FOR A VOLUNTARY TIME-BANK DUE TO AN ILLNESS OR INJURY TO RIVERSIDE COUNTY HUMAN RESOURCES DEPARTMENT, VOLUNTARY TIME- BANK ADMINISTRATOR. INFORMATION ON THIS FORM IS CONFIDENTIAL AND RELEASE OR TRANSFER OF THIS INFORMATION TO PERSONS NOT SPECIFIED IS PROHIBITED.		
Employee's Signature	,	/ / Date Signed
	Physician Information	
Date of onset of condition	on: <u>/ /</u> Diagnosis and nature o	of condition:
Estimated length of incapacity:		
 Is patient able to period 	form normal job duties/usual and customary?	Yes 🗌 No 🗌
•	k with modifications/restrictions? ns/restrictions. If no, estimated return to work date:	Yes 🗌 No 🗌 / /
Physician's Signature	······	Date Signed
License Number (Required)		
Please return this form to:	Voluntary Time-Bank Administrator Riverside County Human Resources Department P.O. Box 1569	
	Riverside, CA 92502-1569	