



**REQUEST FOR ESTABLISHMENT OF A VOLUNTARY TIME-BANK FOR ILLNESS OR INJURY**



TO: VOLUNTARY TIME-BANK ADMINISTRATOR, HUMAN RESOURCES DEPARTMENT

FROM DEPARTMENT: \_\_\_\_\_ DEPT CONTACT: \_\_\_\_\_

**EMPLOYEE SECTION**

I, \_\_\_\_\_, REQUEST THE ESTABLISHMENT OF A VOLUNTARY TIME-BANK FOR THE FOLLOWING REASON(S): \_\_\_\_\_ AND AUTHORIZE DISTRIBUTION OF MY REQUEST ON A: COUNTY-WIDE , DEPARTMENT-WIDE , OR DIRECT TRANSFER BASIS .

FURTHERMORE, I UNDERSTAND THAT MY 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's Signature

\_\_\_\_\_  
Date Signed

**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 NAME: \_\_\_\_\_ EMPLOYEE ID No.: \_\_\_\_\_

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

▪ IF SO, HAS A WORKERS' COMPENSATION DETERMINATION BEEN RENDERED? 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

\_\_\_\_\_  
Date

**HR DEPARTMENT**

HR DEPARTMENT DETERMINATION: REQUEST IS APPROVED  DENIED

Instructions: \_\_\_\_\_

\_\_\_\_\_  
Voluntary Time-Bank Administrator

\_\_\_\_\_  
Date



# VOLUNTARY TIME-BANK PHYSICIAN STATEMENT



EMPLOYEE NAME: \_\_\_\_\_  
*(PLEASE PRINT)*

EMPLOYEE ID No.: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I AUTHORIZE \_\_\_\_\_  
*(PHYSICIAN)* TO RELEASE INFORMATION PERTAINING TO  
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: \_\_\_\_/\_\_\_\_/\_\_\_\_ Diagnosis and nature of condition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Estimated length of incapacity: \_\_\_\_\_

▪ *Is patient able to perform normal job duties/usual and customary?* Yes  No

▪ *Is patient able to work with modifications/restrictions?* Yes  No

▪ *If yes, list modifications/restrictions. If no, estimated return to work date:* \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*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