BILINGUAL VALIDATION/PAY REQUEST FORM

FROM: ______________________ PHONE: ______________ DATE: __________

Complete this form to validate an employee as bilingual and request Bilingual Pay. This form can also be used to cancel an employee's bilingual pay. Send this completed form to the appropriate Human Resources Services Manager upon completion.

Please note that in order for an employee to be eligible to receive bilingual compensation, the bilingual skills must be required to perform the essential duties of a job, at least once a day or five times per week either verbally or in writing.

Section I: Employee Information

Employee Name: ______________________ Employee ID#: ______________

Position Number: ______________ Job Title: ______________________

Department Name: ______________________ Second Language Required: ______________

Bilingual Pay Request				**TAP Employee**	
New	**Change**	**Cancel**	**If cancelling proceed to Section IV**	**Yes**	**No**

Validate Employee as Bilingual (Check Level Required)	
	Level 1 (BC1): Employee communicates verbally in a second language as a requirement of their position.
	Level 2 (BC2): Employee communicates both verbally and in writing in a second language as a requirement of the position.
	Level 3 (BC3): Employee communicates complex technical, medical, **AND** legal information in a second Language.

Section II: Justification

Please provide a detailed explanation for bilingual compensation. Explanation must include: Type of translation being used (verbal or written), essential duties requiring bilingual skills, and the frequency in which the use of a second language is required.

____

____

____

Section III: HR Testing Representative

Name:		Date Tested:
Passed Exam at Level Requested: ☐	Effective Date: ______________ **Must be a beginning of a pay period or date of hire if hired from a bilingual list. Cannot precede date tested.**	Failed Exam: ☐ **Return form to Department.**

Section IV: Department/Service Team Approval

I certify that this position requires bilingual skills and meets the required conditions set forth in the applicable MOU or Management Resolution.

Manager's Signature/Designee: ______________________ Date: __________

Additional Department Review (If required): ______________________ Date: __________

Department Head Signature/Designee: ______________________ Date: __________

HR Services Manager's Printed Name: ______________________ Date: __________

HR Services Manager's Signature: ______________________ Date: __________

Forward original to ACO Payroll for Processing

Section V: ACO Payroll Action

Pay Period Processed:		Processed By:
Retro Pay Processed:	Yes ☐	Not Applicable ☐