RIVCO 1HR
putting people first

BILINGUAL VALIDATION/PAY REQUEST FORM

Reset Form

The Bilingual request is for: From Recruitment/New County Employee   Existing County Employee

Supervisor: _____   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 **TestProctoringUnit@rivco.org**.

Section I: Employee Information

Employee Name: _____   Employee ID#: _____

Employee Email: _____   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 (at least once a day or five times per week) either verbally or in writing in which the use of a second language is required. (Attach justification, if necessary)

_____

_____

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 Designee's Printed Name: _____   Date: _____

HR Designees 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 ☐	