



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