San Bernardino County
Department of Behavioral Health
Employee Intra-Department Reassignment Request

Classification:	
Employee Number:	
Employee Name:	
Current Program/Clinic:	**City:**
Phone Number:	

List the programs you would like to work for:	**List any programs that you <u>do not</u> wish to be considered for:**

Reason for transfer:

Please include a current resumé as an attachment to this form when you submit it to DBH HR OA IV.

This request is good only for one year at date of submission. If you wish to be considered for reassignment after that time, you must fill out another Employee Intra-Department Reassignment Request.

Employee Signature:	**Date Submitted:**

Concur:	Yes ☐ No ☐
If "No," Reason:	
Supervisor Signature:	**Date:**

Concur:	Yes ☐ No ☐
If "No," Reason:	
Program Manager Signature:	**Date:**

Concur:	Yes ☐ No ☐
If "No," Reason:	
Deputy Director Signature:	**Date:**

HRO Review for Good Standing:	
☐ **Approved**	☐ **Not Approved**
Signature:	**Date Completed:**

Original: HR
CC: Employee
CC: Supervisor
CC: Manager