COUNTY OF SAN BERNARDINO
STANDARD PRACTICE

NO 3-1.22	ISSUE 4/96
BY Janet Serros	PAGE 1 OF 2
	EFFECTIVE 7/94
DEPARTMENT BEHAVIORAL HEALTH	APPROVED James McReynolds, Director
SUBJECT CLINICAL THERAPIST REASSIGNMENT REQUESTS	

I PURPOSE

To establish a procedure for Clinical Therapists to request program reassignment

II POLICY

All Clinical Therapist reassignments in the Department are at the discretion of the Director, Assistant Director, and Deputy Directors

III REASSIGNMENT PROCEDURES

A. Procedure 1.

Clinical Therapists seeking reassignment to a specific position may do so if they have.

1 Received prior approval from their Program Manager II (if both positions are located in the same program).

2. Received approval from both Program Managers when the reassignment involves two programs.

3. The Deputy Director responsible for the program(s) in question has also approved the reassignment

4 Received approval from both Program Managers and Deputy Directors when the reassignment is from one division to another

5. If these conditions are met, clinical therapists may proceed by completing a Clinical Therapist reassignment request form (attachment 1)

B. Procedure 2:

If conditions described above are not met, a Clinical Therapist may seek reassignment

through the interview process

1. Clinical Therapists will indicate their interest in participating in the Department's interview process by completing an Employee Intra-Departmental Reassignment Request form (attachment 2), available from the Payroll Office, and submitting it to the Assistant Personnel Officer

2. The Payroll Office will maintain lists of employees requesting reassignment. Payroll staff are responsible for notifying the interviewing authority of the names of employees on the reassignment list.

3. Staff conducting interviews are encouraged to consider employees from the reassignment list for vacancies. It is the responsibility of the staff member conducting interviews to contact employees requesting reassignment in order to schedule interviews with them.

4. If a job offer results from the interview process, the Clinical Therapist should inform his/her Clinical Supervisor by memo and send a copy to the relevant Program Manager, and a copy to the Department of Behavioral Health Payroll Office

LM/amr

REASSIGNMENT REQUEST

TO: ______________________________

Program Manager II, ______________________________

FROM: ______________________________

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DATE: ____________________ Department Start Date: ______________

Position Number: ______________ Position Start Date: ______________

Current Classification: ______________________________

Current Duties: ______________________________

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Name of Immediate Supervisor: ______________________________

Reason for Reassignment Request: ______________________________

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Desired Position/s: ______________________________

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PROGRAM MANAGER	Approved	______	Denied	______
DEPUTY DIRECTOR	Approved	______	Denied	______
DIRECTOR	Approved	______	Denied	______

TO: ______________________________

Deputy Director, ____

FROM: ______________________________

Program Manager II, ____

DATE: ______________________________

Recommend Approval ______________ Recommend Denial ______________

Analysis of Employee Reassignment Request:

Review of Employee Work Standards, (Include Employee's Latest WPE):

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Impact on Clinic/Program If Employee is Reassigned?:

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TO:___________________________________
(Employee Requesting Reassignment)

VIA:___________________________________
(Program Manager II,____________________Program

FROM: Deputy Director, Community Treatment Services

REASSIGNMENT REQUEST DENIED:

REASSIGNMENT REQUEST APPROVED:

If your reassignment request has been approved and a new position has not yet been agreed upon please contact the Department's Payroll Office to ensure that your name has been added to the interview list. If your request has been denied you may resubmit another reassignment request in six months.

DEPARTMENT OF BEHAVIORAL HEALTH
EMPLOYEE INTRA-DEPARTMENT REASSIGNMENT REQUEST

CLASSIFICATION ____________________

EMPLOYEE NUMBER ________

EMPLOYEE NAME ____________________

SOCIAL SECURITY NUMBER ____________

CURRENT PROGRAM/CLINIC ____________________

PHONE NUMBER (   ) ___ - ____

List the programs you would like to work for:	List any program you *do not* wish to be considered for:

This request is good for one year only. If you wish to be considered for reassignment after that time, you must fill out another reassignment request form.

EMPLOYEE SIGNATURE:______________________________ **DATE:**____________

PROGRAM MANAGER SIGNATURE:____________________ **DATE:**____________