

California Department of Human Resources
Oral Bilingual Proficiency Examination Request Form
Bilingual Services Program (BSP)
CalHR-810-BE (Rev. 07/2015)

AGENCY NAME	EMPLOYEE'S DIVISION AND UNIT	LANGUAGE SURVEY COORDINATOR'S NAME ¹
Person Requesting Exam	Title	TELEPHONE NUMBER: E-MAIL ADDRESS:

EXAM REQUEST 1:

LAST NAME	FIRST NAME	WORK PHONE NUMBER
MAILING ADDRESS (for Exam results) Address: City: State: Zip Code:		CONFIRM EXAM DATE & TIME TO EMPLOYEE BY: E-Mail
		LANGUAGE EXAM:

EXAM REQUEST 2:

LAST NAME	FIRST NAME	WORK PHONE NUMBER (Ext .)
MAILING ADDRESS (for Exam Results) Address: City: State: Zip Code:		CONFIRM EXAM DATE & TIME TO EMPLOYEE BY: E-Mail
		LANGUAGE EXAM:

EXAM REQUEST 3:

LAST NAME	FIRST NAME	WORK PHONE NUMBER (Ext .)
MAILING ADDRESS (for Exam Results) Address: City: State: Zip Code:		CONFIRM EXAM DATE & TIME TO EMPLOYEE BY: E-Mail
		LANGUAGE EXAM:

SUPERVISOR'S CONTACT INFORMATION:

NAME:	TITLE and SIGNATURE:
MAILING ADDRESS (for Exam Results) Department: Address: City: State: Zip Code:	CONTACT NUMBER:

CONFIRM EXAM DATE & TIME TO SUPERVISOR BY:
E-Mail Address:

REASONABLE ACCOMMODATIONS (Please Specify):

¹ The Language Survey Coordinator is responsible for your agency's Bilingual Services Program and should be consulted when employees are being certified to determine if this would correct any actual position deficiencies found in the latest language survey.

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<p>DEPARTMENT PAYMENT METHOD:</p> <p>\$115.00/ea. - Purchase/Service Order # _____(Attached)</p> <p>* \$115.00/ea. - Bill Consolidated Contract # _____ *</p> <p>\$115.00/ea. – Cal Card *</p> <table style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center;"><u>X \$115.00</u></td> <td style="border: none; text-align: center;"><u>= \$</u></td> </tr> <tr> <td style="border: none; text-align: right;"># of Exams</td> <td style="border: none; text-align: center;">Cost Per Exam</td> <td style="border: none; text-align: center;">Total Cost</td> </tr> </table> <p style="text-align: center; font-weight: bold; margin-top: 10px;">PLEASE NOTE THAT PAYMENT FROM THE DEPARTMENT IS DUE PRIOR TO EXAM BEING SCHEDULED</p>		<u>X \$115.00</u>	<u>= \$</u>	# of Exams	Cost Per Exam	Total Cost	<p style="text-align: center;"><u>Mail Payment & Request Form To:</u></p> <p style="text-align: center;">CalHR – Office of Civil Rights Bilingual Services Program Attn: Bilingual Testing Coordinator 1515 S Street, North Bldg., Ste. 400 Sacramento, CA 95811-7258</p> <p style="text-align: center; margin-top: 20px;">For Information or Questions: (916) 324-0970 Fax: (916) 327-2349 7-1-1 CA Relay Service Email: bilingual@calhr.ca.gov</p>
	<u>X \$115.00</u>	<u>= \$</u>					
# of Exams	Cost Per Exam	Total Cost					

***IF PAYING BY CONSOLIDATED CONTRACT OR PURCHASE/SERVICE ORDER, PLEASE INCLUDE THE FOLLOWING INFORMATION.**

Name of Person to Invoice:		Unit:	
Address:	City:	State:	Zip
Code: Phone number:		Fax number:	

***IF PAYING BY CAL CARD:**

Name of the Candidate(s) for which this payment should be applied:

1.
2.
3.

Number of Exams	Item Description	Cost Per Item	Total Cost to be Charged
1	Bilingual Oral Fluency Examination	\$115.00	

Cal Card

Name of Department as it appears on the Cal Card:

Cal Card #:	Expiration Date:
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Mailing Address (to send receipt):

Address:	City:	State:	Zip:
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Contact Telephone Number:

THE EMPLOYEE AND SUPERVISOR WILL RECEIVE CONFIRMATION BY E-MAIL OR FAX, APPROXIMATELY 7 DAYS FROM THE DATE THE EXAMINATION IS SCHEDULED. NO EXAMINATION WILL BE SCHEDULED UNTIL PAYMENT AUTHORIZATION IS RECEIVED.

I hereby certify that I am authorized to submit a request for bilingual fluency examination, as or on behalf of, the department's testing officer.

Signed:	Title:	Date:
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