

REHABILITATION COMMITTEE REQUEST FOR TRANSFER ON COMPASSIONATE GROUNDS

Instructions

- Request for transfer on compassionate grounds must meet with a stringent criteria. Only Regular employees who have completed their initial probationary period may be given consideration. Each request will be dealt with on its merits.
- The application must be completed jointly whenever possible by the applicant and their manager/supervisor and/or human resources personnel. Forward the completed form to: Secretary, Rehabilitation Committee, BC Public Service Agency, PO Box 9404 Stn Prov Govt, Victoria BC V8W 9V1.

Freedom of Information and Protection of Privacy Act
 The personal information requested on this form is collected under the authority of employee terms and conditions of employment established under the *Public Service Act* and *Public Service Labour Relations Act*. Questions about the collection or use of this information can be directed to the Manager, Disability Management Programs at 250 387-0547 PO Box 9404 Stn Prov Govt, Victoria BC V8W 9V1.

EMPLOYEE INFORMATION					
NAME	GENDER (statistical purposes only) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH YYYY / MM / DD	SOCIAL INSURANCE NO.		
CURRENT ADDRESS – <i>include city, province, postal code</i>			HOME PHONE NO.	WORK PHONE NO.	
EMPLOYING MINISTRY	BRANCH / WORK ADDRESS – <i>Include city, province, postal code</i>				
SENIORITY DATE YYYY / MM / DD	PRESENT CLASSIFICATION	GRID LEVEL	BI-WEEKLY RATE OF PAY	UNION / ASSOCIATION	<input type="checkbox"/> REGULAR <input type="checkbox"/> AUXILIARY
WHAT ARE THE GROUNDS FOR YOUR REQUEST?					

IF A LATERAL TRANSFER IS NOT FEASIBLE, WILL YOU ACCEPT A VOLUNTARY DEMOTION? YES NO

WHAT STEPS HAVE YOU TAKEN TO SECURE ALTERNATE EMPLOYMENT WITHIN THE PUBLIC SERVICE?

LIST TYPES OF OCCUPATIONS PREVIOUSLY HELD:

OTHER EMPLOYMENT INTERESTS:

CURRENT EDUCATION LEVEL COMPLETED:

ADDITIONAL SCHOOLING SKILLS:

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, hospital or other Medical Agency having medical records pertaining to the person named below, to disclose the information contained in these records to the Rehabilitation Committee.

NAME	RELATIONSHIP TO EMPLOYEE
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APPLICANT'S SIGNATURE	DATE SIGNED YYYY MM DD
X	

MANAGER/SUPERVISOR OR HUMAN RESOURCE OFFICER/PERSONNEL OFFICER COMMENTS

MANAGER/SUPERVISOR OR HUMAN RESOURCE OFFICER/PERSONNEL OFFICER SIGNATURE	PRINT NAME	DATE SIGNED YYYY MM DD
X		