

**County of San Bernardino
Department of Behavioral Health**

Sequence # _____

Routing # _____

POSITION/JUSTIFICATION FORM

Classification	Position Number	Status of Position	Funding Source	Cost Center	Unit	Person Being Replaced

Workdays/Hours:
Work Location:
Skills:

JUSTIFICATION FOR FILLING:	
IMPACT OF NOT FILLING:	

Deputy Director Approval Date: _____