Translation Services Program for Emergency Personnel
Application for Verbal Language Skill Evaluation

Part I-Employee Form

Name of Employee: _____
Department: _____ Date of Hire:_____
Phone Number: _____ Employee ID No._____
Supervisor: _____

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1. What language are you testing to be certified in?
   _____

2. How often will you be using your bilingual skills?
   _____ daily_____ weekly_____ monthly _____other *(please specify frequency)*

3. Please describe situations and the audiences in which your bilingual skills will be used:
   _____
   _____
   _____
   _____
   _____
   _____
   _____

4. Have you read the Translation Services Administrative Directive?
   Yes_____ No _____

5. Do you agree to the responsibilities outlined in the directive? Yes____ No ____

You will be tested by an independent professional evaluator. Please list 2 dates and times you would be available for testing within the next two weeks. You will be contacted to confirm the evaluation date.

1st choice: _____ 2nd choice: _____

_____ _____
Employee Signature Date

Please have your supervisor and director complete Part II-Supervisor Form and forward Part I and Part II to Organizational Development.

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Part II -Supervisor Form

1. Name of Employee:
   _____

2. Do you agree to the statements made on the Part I – Employee Form regarding the frequency and situations in which bilingual skills will be used for this employee? Yes_____ No_____

3. Do you support this employee to be tested for bilingual certification?
   Yes_____ No _____

4. Describe the value added by having this employee certified as a translator:
   _____
   _____
   _____
   _____
   _____

5. Does this employee have any active disciplinary issues If yes, please explain
   _____
   _____
   _____

6. Do you agree to support the responsibilities for bilingual employees outlined in the Translation Services policy? Yes_____ No _____

A testing date/time will be arranged for your employee. Following the evaluation, results will be sent to you and the employee. Human Resources will make the necessary changes to process the translator's additional payment of $35/month.

_____ _____
Supervisor Signature Date

_____ _____
Director Signature Date

_____
Department

Please forward this form to Organizational Development. If you have any questions, please contact Organizational Development at 972-466-3172 or email: 41164@cityofcarrollton.com

Thank you for supporting this program and your employee!