CARROLLTON

TEXAS

Translation Services Program
Application for Verbal Language Skill Evaluation
Part I -Employee Form

Name of Employee: _____

Department: _____   Date of Hire:_____

Phone Number: _____   Employee ID No._____

Supervisor: _____

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 policy? 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 three weeks. You will be contacted to confirm the evaluation date.

1st choice: _____   2nd choice: _____

_____   _____
Employee Signature   Date

Please have your department director complete part II, Director Form,
and forward Part I and Part II to Organizational Development.

11/14/11

Translation Services Program
Application for Verbal Language Skill Evaluation
Part II -Department Director 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 currently active disciplinary or performance 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. Workforce Services will make the necessary changes to process the translator's additional payment of $50/month.

_____   _____

Dept. Director Signature   Date

_____   _____

Supervisor Signature   Date

_____

Department

Please forward this form to Workforce Services. 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!

11/14/11