**Language Evaluation Form**

**Applicant Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above individual is applying to be a volunteer medical interpreter at Open Door Clinic. As a free medical clinic serving uninsured and underinsured low income individuals in Addison County, Vermont, USA, we provide essential medical care to individuals of many backgrounds. Approximately 30% of our patients are Limited English Proficiency (LEP) patients requiring assistance of medical interpreters to facilitate communication and thus insure high quality medical care. Although we have access to telephonic interpretation, we rely most heavily on volunteer medical interpreters available for in-person interpretation at clinics and referral appointments. While clinic staff can train novice interpreters in basic medical interpretation techniques, we can not hope to teach volunteers another language. So, we require that interpreter volunteers exhibit proficiency/fluency in both English and their target language(s) before accepting them as a medical interpreter with our organization.

As part of our screening process, please complete the following form regarding this potential volunteer’s language skills and likelihood of success as a medical interpreter. Please feel free to contact Open Door Clinic’s Outreach Coordinator, Kay Freedy, should you have questions or wish to discuss any part of your evaluation further. You can reach Kay at 802-388-0137 or [outreach.opendoor@gmail.com](mailto:outreach.opendoor@gmail.com).

**Once completed, please return this form directly to:**

**Open Door Clinic**

**100 Porter Dr.**

**Middlebury, VT**

**USA**

**Fax: 802-388-4498**

Thank you!

Evaluator’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evaluator’s relationship to the applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Under what circumstances have you observed the applicant’s use of the identified language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a professional language educator? **Y / N**

Are you a native speaker of the target language? **Y / N**

Are you familiar with the applicant’s *current* language abilities? **Y / N**

If your knowledge of the applicant’s abilities is not current, for what time period are you able to comment on their language abilities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the best descriptor of the applicant’s skills in each of the following categories. For more information, you may wish to reference ACTFL Proficiency Guidelines.  *A review of these may be accessed at:* [*http://www.gwu.edu/~slavic/actfl.htm*](http://www.gwu.edu/~slavic/actfl.htm)*.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Novice | Intermediate | Advanced | Advanced High | Superior |
| Listening |  |  |  |  |  |
| Speaking |  |  |  |  |  |
| Reading |  |  |  |  |  |
| Writing |  |  |  |  |  |

Please select one of the following descriptions of the applicant’s overall language skills:

❑ Proficient

❑ Fluent

❑ Native speaker

❑ None of the Above

Are you aware of any translating or interpreting experience this applicant has had? **Y / N**

If yes, please briefly describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any hesitations you may have about recommending this individual as a volunteer medical interpreter with our organization. You may attach additional pages as necessary. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Thank you for your time and thoughtful feedback. We appreciate your willingness to help us provide the highest quality medical care for our LEP patients. By signing below, you indicate that, to the best of your knowledge, the information provided here is complete and accurate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evaluator’s Signature Date