Oregon AHEC Spanish Health Care Interpreter Program
Pre-Assessment Application

(*Please print legibly!*)

Date: ____________

Applicant's Name: ____

Address: ____

City: ______________ **State:** _________________ **Zip code:** ___________________

Daytime/message Telephone: _______________ **Best time to call** _______________

Cell phone: ______________________ **Email Address:** ______________________

Last four digits of Social Security Number: __________ **Date of birth** ___/___/___

(Check one): ☐ **Male** ☐ **Female** **Age:** __________

Ethnicity: (Check all that apply):

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian
☐ More than one (please list)________________

Program Claim Status (check all that applies to your situation. *Please see <u>Attachment B</u> for definition of terms*):

☐ Financially Disadvantaged ☐ Rural ☐ Minority

☐ English was a second language growing up

☐ My parents did not go to college / I will be the first in my family to attend college

☐ Qualified for free or reduced fee school lunch

<u>Education</u>:

High School Diploma ☐ **Yes** ☐ **No** **If yes, where obtained** _____________

If no, did you earn your GED? ☐ **Yes** ☐ **No**

Do you have a college degree? ☐ **Yes** ☐ **No** **Degree Obtained:** _________

If yes, date of completion: _______________

List Colleges or Universities previously attended (including country if not in USA):

____

____

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Please tell us about your work and experience:

Do you have any Healthcare certifications or licenses? ☐ Yes ☐ No

If your answer is yes to the question above, please indicate what:

____

Current Job: ______________________ Department: ___________________

Briefly describe your job duties: ______________________________________

____

I work in _____________ (town/community in Oregon) at ___________________ (name of facility), approximately _______ hours per (week or month –circle one)

Work Role: Do you currently work as a health care interpreter or bi-lingual worker in a healthcare environment (in a hospital, health or mental health department, or health clinic)? ☐ Yes ☐ No

Have you ever worked with Spanish speaking populations? (Describe) _________

____

____

What do you consider your native language? ☐ Spanish ☐English ☐Other ______________________

Do you read, write and speak in both languages? Please describe abilities:

____

____

____

____

____

Length of Experience: How many years experience do you have interpreting?

Medical __________ Other __________

How do you plan to use the Health Care Interpreter Training when you have completed the program?

____

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What strengths and background experiences do you have that would support your success as a Health Care Interpreter?

____

____

Do you have any teaching skills or an interest in training to be a Health Care Interpreter Trainer? ____

Person you gave reference form to complete (Due 3/10/08):

____

Are you available for a 1 ½ hour Interview/Assessment?

__________ **Best Dates (Date Range is 3/17-3/19/2008)**

__________ **Best Times**

I understand that the interview may be tape recorded for the use of the interview panel in completing assessment of the applicant's language skills. All tapes will be destroyed after the candidate selection process is competed.

Applicant signature: ______________________________ **Date:** __________

Please submit your application form to arrive by March 10, 2008 to:

Cascades East AHEC, 2500 NE Neff Rd., Bend, OR 97701
Or electronically to jvalenti@cascadehealthcare.org

Please include your $30 Assessment fee with your completed application.

Method Of Payment:
Please Select One A or B:

A. Personal or Bank Check ? ☐ Yes
Please Make Check payable to Cascades East AHEC

B. Credit Card? ☐ Yes
❒ Visa ❒ MasterCard ❒ Discover ❒ AMEX

Name of Cardholder (as Appears on Card) ____________________________________
Billing Address of Cardholder (if different than applicant) __________________________
City______________State___________Zipcode______________
I authorize payment of the $30 non-refundable assessment fee to be charged to my card.

Card # ___________________________ Exp. Date __________

Cardholder Signature

Oregon AHEC Spanish Health Care Interpreter Program

CONFIDENTIAL REFERENCE INFORMATION FORM

(To be completed by a person who can verify your intent to serve as a health care interpreter in your community)

Applicant's name: ______________________________

This student is applying to participate in educational training to become a Spanish Health Care Interpreter. Please assess his/her suitability as a participant in this program. We are interested in selecting students who:

- ✓ Have a commitment to work in their communities as a health care interpreter
- a. Are already bilingual and can pass the entrance examination process
- b. Have a definite goal to pursue a health care interpreter career and is willing to commit to attend classes regularly and successfully complete the entire program
- ✓ Have demonstrated strong skills in communication that would make him/her a good interpreter candidate
- ✓ Has demonstrated commitment level and self-motivation that will enable student to complete this intensive 6 month training program

In comparison with other students you have known; please evaluate the applicant in the following areas (Circle the number that best describes the applicant):

	Highest			Lowest	
MOTIVATION (self-starter)	5	4	3	2	1
COMMUNICATION SKILLS (verbal skills and expression)	5	4	3	2	1
INTERPERSONAL SKILLS (maintains harmonious and cooperative work-relations)	5	4	3	2	1
COMMITMENT (follows through, keeps agreements, etc.)	5	4	3	2	1
PROFESSIONALISM (uses appropriate language, dress, and conduct)	5	4	3	2	1

PROBLEM SOLVING/CRITICAL THINKING (identifies work-related problems and solutions)	5	4	3	2	1
TIME MANAGEMENT (regularly on-time, prioritizes tasks, and reliability)	5	4	3	2	1

For additional writing space use the back of this page:

Student's strengths as you see them:

Student's weaknesses as you see them ("none apparent" is an acceptable answer):

Why do you think this person would be successful in the health care interpreter training program?

Does this person keep commitments and is this demonstrated in his/her attendance record?

Are you currently the employer of this person? ☐ Yes ☐ No

Do you have plans to use this person as an interpreter in your organization?

If this potential student is your employee, are you willing to provide the student 32 hours of released time from work to complete the clinical portion of healthcare interpreter training?

☐ Yes ☐ No ☐ Unsure/Need more information ___________

****

Evaluator's Name (please print): ________________________

Evaluator's Institution/Agency (if applicable): __________________________

Contact Information – Work Phone Number: __________________E-mail ________________

Mailing Address _________________________________

City __________ State _______ Zip _________

Do you represent a potential employer of this student after he/she finishes this program?

☐ Yes ☐ No

Occupation and/or relationship to student: ____

Signature: ________________________ Date: _______

Please return this form directly to: **Cascades East AHEC, 2500 NE Neff Rd., Bend, OR 97701**
Or by e-mail to jvalenti@cascadehealthcare.org

FORMS MUST BE RECEIVED In OUR OFFICE BY MARCH 10, 2008