UAMS REGIONAL PROGRAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Medical Interpreter Professional Assessment Test

Request for Annual Qualification Assessment

Please print or type all information

I. Interpreter Information

Last Name ______________________
First Name ______________________
Middle Initial ______________________
Maiden Name ______________________

a. Where may we contact you?

Phone ______________________
Mailing Address ______________________
City ______________________
State _______ **Zip** ______________
Email ______________________

b. Language Proficiency[1]

I am bilingual in English and ______________________

c. Practice Setting

Program Completion Date ______________________
Business\Clinic Name ______________________
Business Mailing Address ______________________
City ______________________
State _______ **Zip** ______________
Primary Specialty ______________________
Setting (see list on reverse) ______________________
Other setting not listed ______________________

II. Interpreter Availability Information[2]

☐ Written Test ($30.00 per attempt) ☐ Skills Test ($45.00 per attempt)
Payment should be made payable to: **MITP Regional Programs**

a. Date(s), Time Preference (list at least three options):

Preference	Month	Day[3]	Time[4]
1			
2			
3			

III. Interpreter Training and Testing Information

a. Formal/Special Training

Medical Interpreting Program ______________________
Program Completion or Certificate Awarded Date ______________________
City ______________________ State

b. Testing Status

☐ Written test date ______________ ☐ Skills test date ______________

---

[1] English Proficiency is required
[2] Prerequisite: you must take the written test prior to the skills test
[3] Day: Monday through Friday only
[4] Morning time ranges begin at 8:30 a.m. until noon, afternoon time ranges begin at 1:00 p.m. until 4:40 p.m. When scheduling your time preference allow 90 minutes for the written test. Allow 20 minutes for skills test.

Setting

AHEC Clinic Main
AHEC Clinic Satellite
Arkansas Dept of Health
Business
Cert Rural Health Clinic
Church
Civic/Convention Ctr.
College/School/University
Community Health Center
Detention Center
Elementary/Jr HS/HS
Foreign Country
Group Family Practice
Group Non-Family Practice
Home Health Care/Hospice
Homeless Center/Shelter
Hospital
Hospital-Based Practice
Hospital-Night Float
Hotel/Motel
Indian Health Service
Library/Center
Medical School (Academic)
Migrant Health Center
Military
Multispeciality Group
Natl Health Service Corps
Non Health Care
Non Heatlh Care
Nursing Home
Pharmacy - Hospital
Pharmacy - Private
Phys. Office/Clinic/etc.
Restaurant/Country Club
Retired
Reynolds Center on Aging
Senior Housing Center
Solo Practice
VA Clinic
Other – specify on front

ATTENTION APPLICANTS DO NOT WRITE BELOW THIS LINE

OFFICAL USE ONLY

I. Test Results Information

Written Test Highest Score ______________ Request Form received ______________
Skills Test Highest Score ______________ Deposit(s) received ______________
Approved ______________
Effective date ______________

PROCESSED BY ______________

DATE ______________

Please fax completed form to Angelina Levitskaya at 501 686-8506.