

LANGUAGE SKILLS ASSESSMENT FORM

CANDIDATE INFORMATION:	Date: _____
Name: _____	RATING:
Social Security Number: _____	

Language to Be Assessed:

Rating for Bilingual Ability

- | | | |
|-----------|--|--|
| 1. | Conversational Ability in Foreign Language | <input type="checkbox"/> Pass

<input type="checkbox"/> Fail |
| 2. | Ability to Translate from Foreign Language into Written English | <input type="checkbox"/> Pass

<input type="checkbox"/> Fail |
| 3. | Ability to Translate from English into Written Foreign Language | <input type="checkbox"/> Pass

<input type="checkbox"/> Fail |
| 4. | Writing Ability in Foreign Language | <input type="checkbox"/> Pass

<input type="checkbox"/> Fail |

(signature TLD Language Specialist)

(Print Name)



FAX TO:

The Language Doctors, Inc.

ATTN: NICOLE WELLS
 Fax: 202-547-2311

LANGUAGE ASSESSMENT SCHEDULE FORM

1	Date of Request	Assessment Requested by	Division/Code	LSAF faxed to:	Date/Time of Assessment:	Candidate's Name:	Language Assessed:
		Tel/Fax No.:		Tel/Fax No.:		Candidate's SS# (last 4 digits) XXX – XX-	Tel/Fax No. for Assessment:
		T:		T:			T:
		F:		F:			F:
2	Date of Request	Assessment Requested by	Division/Code	LSAF faxed to:	Date/Time of Assessment:	Candidate's Name:	Language Assessed:
		Tel/Fax No.:		Tel/Fax No.:		Candidate's SS# (last 4 digits) XXX – XX-	Tel/Fax No. for Assessment:
		T:		T:			T:
		F:		F:			F:
3	Date of Request	Assessment Requested by	Division/Code	LSAF faxed to:	Date/Time of Assessment:	Candidate's Name:	Language Assessed:
		Tel/Fax No.:		Tel/Fax No.:		Candidate's SS# (last 4 digits) XXX – XX-	Tel/Fax No. for Assessment:
		T:		T:			T:
		F:		F:			F: