



Date: _____

Applicant Information:

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ Cell Phone: (____) _____

E-mail: (Required) _____
(Print Legibly)

Primary Language: _____ Second Language: _____

Third Language, if any: _____

Do you currently work as an interpreter? Yes _____ No _____

How often do you interpret? Daily ____ A few times/week ____ A few times/month ____
Not very often ____ Not Applicable _____

How many **total hours of interpretation** did you provide in the last 30 days? _____ Hours

Have you interpreted in a medical setting before? Yes _____ No _____

(If yes, please explain) _____

Name of Sponsoring Organization: _____

Contact Name at Sponsoring Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ E-mail: (Required) _____

Please note: Proof of language proficiency is required of all applicants

Application Information

Space is limited and very competitive. Approved participants **MUST** attend the entire 64 hours in order to take the final exam and receive a certificate of successful completion. Failure to attend any portion of the course will result in failure of the course. Participants who fail to attend the entire course will be required to return all provided training materials.

Application Deadlines for the 2018 Summer-Training:

Registration opens July 9, 2018

Registration closes July 31, 2018

Applications received before or after the registration period will NOT be accepted.

Incomplete and ineligible applications will NOT be accepted.

Please include the following information with your application.

1. Bridging the Gap Application Form
2. Resume/Curriculum Vitae describing your experience with medical interpreting.
3. Proof of language proficiency for:
 - a. English language, and
 - b. Non-English language
4. Sponsoring Agency:
 - a. Sponsoring Agency Information Form, and
 - b. Sponsoring Agency Language Proficiency Certification

We care about your privacy, please DO NOT e-mail these forms. We ask you to please fax, mail, or hand deliver your application as follows:

**Fax: 801-538-9495
Attn: Edwin Espinel
Utah Department of Health**

**Mail to: Attn: Edwin Espinel
Utah Department of Health
PO Box 142107
Salt Lake City, UT 84114-2107**

**Deliver: Attn: Edwin Espinel
Utah Department of Health
288 N. 1460 W.
Salt Lake City, UT 84114-2107**

Thank You!