CABINET FOR HEALTH AND FAMILY SERVICES

Steven L. Beshear
Governor

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Janie Miller
Secretary

CHFS SPANISH LANGUAGE PROFICIENCY ASSESSMENT
REGISTRATION FORM

PLEASE TYPE OR PRINT CLEARLY

1. Name:	**2. Testing Date/Location:** **Please indicate which testing session you are registering for:**
3. Name of Employer:	
4. Job Title:	**_____ Thursday, October 21, 2010 – Frankfort** **_____ Thursday, December 9, 2010 – Frankfort**
5. Mailing Address:	**Testing begins promptly at 9AM and ends by no later than 4PM. Depending on the number of participants, it may end earlier. Detailed information and directions will be provided prior to the testing date.**
6. Email Address:	

7. Telephone: Work: Home/Cell:

8. Please detail your background/knowledge/experience with English and Spanish and/or interpreting. Use an additional sheet if necessary: