COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

REQUEST FOR INTERPRETATION/TRANSLATION SERVICES

Request Date _____

Requestor _____

Requestor's Phone _____

Program/Unit _____

Request Type: □ Interpretation □ Translation

Language(s) Requested _____

Name of Employee requested to interpret/translate: _____

Employee's Phone _____

Description of Request

_____

_____

_____

_____

Target Completion Date: _____

To Be Completed by Level of Program Manager or Above

Received Date _____

Program Manager or Above: _____

□ Approved □ Denied

_____ _____
Program Manager Signature Date

If denied/declined, a detailed explanation must be provided below:

_____

_____

_____

_____

_____

To Be Completed by Employee Requesting Interpretation/Translation Services

Received Date _____

Employee Name: _____ Employee Number: _____

Employee Signature: _____ Date: _____

Return Completed and Signed form to:
Ethnic Services Manager
Program Support Bureau - Quality Improvement Division
Fax: (213) 252-8747