

NEW YORK STATE DEPARTMENT OF CORRECTIONS
AND COMMUNITY SUPERVISION
**WAIVER OF RIGHT
TO FREE ORAL INTERPRETATION SERVICES**

NAME OF LIMITED ENGLISH PROFICIENT (LEP) CLIENT _____
_____RECIPIENT / _____REPRESENTATIVE

I have been told that I have a right to free interpretation from the New York State Department of Corrections and Community Supervision.

I understand that I can have an interpreter at no cost to me or my family.

I understand that I am allowed to change my mind at any time and ACCEPT a free interpreter.

I choose NOT to use a free interpreter at this time, and will instead utilize _____
(unless this is an emergency situation, my interpreter is at least 18 years of age):

SIGNATURE* _____ **DATE** _____

INSERT A PLAN FOR INTERPRETATION SERVICES BELOW:

NAME OF EMPLOYEE _____ **DATE** _____

Facility/Area/Regional Office _____

E-MAIL ADDRESS _____ **PHONE NUMBER** _____

Whenever applicable: The interpreter named below has read this form to the LEP person in his or her primary language.

Name of Interpreter _____ Date _____

Relationship to Client _____

Signature of Interpreter _____ Date _____

*A signature is only needed if the contact with the LEP person or representative is in-person.
NOTE: LEP persons are individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.