

Testing Request Form

Student Name: _____ **Panther ID:** _____ **Phone:** _____

1. Campus: _____ **Subject/Course:** _____ **Semester:** _____

Day(s) Class meets: _____ **Start Time:** _____ **End Time:** _____

Instructor's Name: _____

Classroom Location: Bldg. _____ Room: _____

2. Do you need a room with specific technology? No Yes (*specify*)

Check the testing accommodations you are approved to use if applicable during your exams:

Text-to-Speech/Dictation Computer CCTV Reader Scribe Interpreter Other

Complete # 3 - 5 with your instructor.

3. **Student's Testing Schedule** (If additional space is needed, please complete another T.R.F.)

Day	Date	Start Time	Time Given in Class (Hours: Minutes)

4. **Instructor, please select ONE exam delivery method:**
 Exam sent via E-mail (include students' name and course).
 Deliver the exam to Disability Services.

5. **Instructor, please to select ONE exam return method.**
 E-mail within **1 business day**.
 Student returns in a sealed envelope.
 Retrieval of exam by designated individual from Disability Services
 Deliver the exam to _____ within **3 business days**. (*N/A for Summer Semester*)
Building **Room** *Atlanta Campus only*

Instructor & Student Acknowledgement Statement:

By signing this document, we both have reviewed and approve the student's testing schedule. As the student, I am responsible for knowing my exam schedule and responsible for communicating any requests to change this schedule to my instructor first. As the instructor, I understand that it is my responsibility to notify Disability Services of any changes to this testing schedule.

Student's Signature: _____ **Email:** _____ **Date:** _____

Instructor's Signature: _____ **Email:** _____

Instructor's Phone: _____ **Date:** _____

(Office or Department)