

Disability Services Exam Form

Test Date: _____

Assigned Room/Seat: _____

COURSE CODE/ NAME: _____

STUDENT LAST NAME: _____ STUDENT FIRST NAME: _____ ACCOMMODATIONS: _____

START TIME: _____ ESTIMATED END TIME: _____ ACTUAL END TIME: _____

INSTRUCTOR: _____ CONTACT INFO DURING EXAM: _____

Alternate Contact Name & Info: _____

Exam Date & Time

This exam will be taken on _____ at _____
(Date) (Time)

- Time (in Minutes) for Class: _____

Approved Exam Materials

- Calculator
- Computer
- Blue Book
- Formulas
- Dictionary
- Nothing Allowed**
- Open Book
- Open Notes
- Scantron – Please Specify – Half, Purple, Full, etc. in Comments
- Other _____

Comments/Special Notes: _____

Signature Acknowledging Receipt of Exam: _____ Date Sent/Picked Up: _____

Signature of Courier if Applicable: _____ Date Delivered: _____

Method of Receipt

Date Received: _____

- Campus Mail
- E-Mail
- Student Delivered/Brought Exam
- Hand Delivered by Professor
- Picked up by Courier

Method of Return

- Pick Up (Most Secure Method)**

Instructor: _____

Authorized Personnel: _____

- E-mail** (Please Provide Email Exam is to be sent to)

- ODS Courier to Department Name and Address**

- Campus Mail:** _____