TO: Testing Center

FACULTY NAME: ______________________ OFFICE/BUILDING: ___________ EXT: ______________

DATE TEST SENT: ______________ DEPT & COURSE #: ________________________________

MAKE-UP TEST DATE:

_____ Student must take the exam ____________________________ (time/date).

_____ Student may take the exam any time the Testing Center is open on a walk-in basis not to exceed:

__________________________ (time/date).

PLEASE NOTE: The Testing Center will firmly honor your deadline unless we hear from you by email or phone. Please do not send word with a student regarding deadline changes.

NAME OF STUDENT(S): ______________________________________________________________

REGULAR CLASS TIME allowed for test: (check one) ☐ 50 min. ☐ 75 min. ☐ Other ______

SAS will determine the total testing time based on the individual student’s accommodations.

AIDS PERMITTED: Please check all aids allowed for this exam:

_____ calculator (circle type) basic/scientific/graphing ☐ scrap paper (provided, not provided)

_____ textbook ☐ notes

_____ charts, graphs, tables ☐ other (please explain)

EXTRA TESTS: I have included ______ extra tests for any student not listed by name.

COMPLETED TEST INSTRUCTIONS:

_____ SCAN and SHRED test (tests will be held for a brief security period)

_____ SCAN and HOLD test for me to pick up

OTHER SPECIAL INSTRUCTIONS: ____________________________________________________

View Testing Center hours at www.kent.edu/stark/testing-services.