

CHICAGO STATE UNIVERSITY

**ABILITIES OFFICE OF
DISABLED STUDENT SERVICES**

TESTING FORM

Special testing is being requested for the student who is named herein. Please complete and return this form to ensure that the Abilities Office provides the appropriate test environment. Read the items below and check the boxes appropriate to the test being given. All tests will be supervised by staff of the Abilities Office.

STUDENT NAME AND ID# _____

Exam Date/Time _____ Course _____

Instructor _____ Location _____

Telephone _____ E-mail _____

How long should the test be administered? _____

Other instructions (please specify) _____

RULES FOR EXAM ADMINISTRATION

(Circle One of Each)

			Comments
Open Book	Yes	No	_____
Can use notes	Yes	No	_____
Calculator	Yes	No	_____

(Other specifications) _____

NOTE:

INSTRUCTOR PLEASE MAKE COPIES OF TESTING FORM FOR EACH TEST TO BE GIVEN TO THE STUDENT (e.g., 3 tests = 3 copies to be completed and delivered to the Abilities Office 48 hours prior to exam date).

(TURN OVER)

INSTRUCTIONS FOR RETURN OF EXAM TO INSTRUCTOR

PLEASE CHECK ONE

EXAM will be picked up

Student will return EXAM

EXAM will be returned by Abilities Office Staff

EXAM to be delivered to (Location) _____

OTHER instructions (Please specify) _____

COMMENTS _____

NOTE: IF THE EXAM IS NOT TAKEN ON THE SPECIFIED DATE, THE EXAM WILL BE RETURNED TO INSTRUCTOR

Instructor Signature

Date

**NOTE: PLEASE RETURN TESTING FORM TO CRSUB ROOM 190*
Attention: Dr. Hall (ext. 2380)**

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(Office Use Only)

EXAM ADMINISTERED BY: _____

DATE OF EXAM: _____ START _____ FINISH _____

COMMENTS:
