

Center for Learning Resources Testing Authorization Form

Please Note:

1. All test requests must be completed and submitted to the CLR within *at least five (5) business days* of test date.
2. Instructor and student should decide upon mutually agreeable date and time.
3. CLR will NOT administer any exam without this form being completely filled out, signed and attached to the exam.

To be filled out by Student:

Student Name (please print): _____

Course Name and Number: _____

Scheduled Date of Exam at CLR: _____ Scheduled Time of Exam at CLR: _____

Approved Accommodations:

- | | |
|---|--|
| <input type="checkbox"/> Extended time | <input type="checkbox"/> Private Space |
| <input type="checkbox"/> Recorded Exam | <input type="checkbox"/> Scribe/Reader |
| <input type="checkbox"/> Use of Calculator (<i>select one</i>): | <input type="checkbox"/> Other: (<i>please describe</i>) _____ |
| <input type="radio"/> Scientific <input type="radio"/> 4-function <input type="radio"/> Graphic | |

To be filled out by Instructor:

1. **Standard Class Time Allowed for Test:** (check one) 50 min 75 min Other _____
(CLR will calculate total testing time based on each individual student's **approved** accommodations.)
2. **Testing Instructions:** _____
(Specify: open/closed book, calculator (Scientific/4 Function/Graphing), crib sheet, may write directly on exam, online test, etc.)
3. **Please initial if student is permitted to keep the Examination Question(s):** _____
4. **Test brought to CLR (WH Rm 133) by instructor or student in a SEALED, SIGNED envelope. Please check:** Instructor Student
5. **Please check the method by which you would like the test returned:**
 - Instructor or authorized staff member will pick up the test. (CLR will return the exam if it is not picked up within 5 business days.)
 - CLR staff will return the test to the department's main office (2 business day turnaround).
Please indicate Department/Office Location: _____
 - The student will return the test in a sealed envelope immediately after the exam.
 - Sent by campus mail.

Instructor's Name: _____ Phone #: _____
(Please Print)

Instructor's Signature: _____

CLR OFFICE USE ONLY

Test delivered by: _____	Date: _____	Time: _____
Test received by: _____	Date: _____	Time: _____
Test administered by: _____	Date: _____	Time: _____
Test returned by: _____	Date: _____	Time: _____