

PTC Disability Services Alternative Testing Request Form

(Office only) Test #	
(Office only) Initials	
(Office only) Test Completed	

1. Delivery Date: _____
 Class: _____
 Instructor's Name _____ Instructor's Contact# _____
 Name of Student: _____

2. Date and Time Student will take exam: _____
 Amount of time class is allowed to take exam: _____
 Date instructor will pick-up exam: _____

3. **Please check any of the following which are allowed for the student to use during testing, if none apply check N/A:**

- | | |
|--|--|
| <input type="checkbox"/> Calculator
<input type="checkbox"/> Card prompter
<input type="checkbox"/> Formula sheet
<input type="checkbox"/> Multiplication table
<input type="checkbox"/> Other (please explain): _____ | <input type="checkbox"/> Open book
<input type="checkbox"/> Open notes
<input type="checkbox"/> Periodic table
<input type="checkbox"/> N/A |
|--|--|

----- *For **DISABILITY SERVICES** Use Only* -----

Testing accommodations Received by Student:

- | | |
|---|---|
| <input type="checkbox"/> Extended time
<input type="checkbox"/> Low Distraction room
<input type="checkbox"/> Enlarged Print (____ font) | <input type="checkbox"/> Reader
<input type="checkbox"/> Scribe
<input type="checkbox"/> Other: _____ |
|---|---|

Date test administered: _____ Time allowed: _____ hours _____ minutes

Start Time: _____ a.m. / p.m. End Time: _____ a.m. / p.m.

Date: _____ Student Signature: _____

Date test picked-up: _____ Instructor signature: _____