STUDENTS WITH DISABILITIES SERVICES

EXAM REQUEST FORM

Student: ___________________________ Course Title and #: ___________________________

INSTRUCTOR: Complete ALL sections below
Send this completed form and EXAM to Students with Disabilities Services Office

CLASS Exam Date: ________________ CLASS Exam Time: ________________
Amount of time CLASS is allotted for exam: __________ hour(s) __________ minute(s)

Instructor authorizes the CLASS to use the following during exam: (Check all that apply)

☐ Scratch paper ☐ Notes ☐ Textbook(s) ☐ Formulas
☐ Tables ☐ Calculator ☐ Other: __________________________

________________________________________________________________________

Does this exam require a scantron: ☐ Yes ☐ No

Scheduling Instructions: (Check one)
Student may schedule exam for another date. ☐ Yes ☐ No
If Yes, Exam must be completed by: (Date) ______ / _______ / ________

INSTRUCTORS: Please indicate how you would like the completed exam returned

Please provide appropriate information including name and signature

☐ Hold for pick up at Student Services Front Desk (Sarasota-Manatee Campus C107)

☐ Send via campus mail (Indicate Mail Point) _________

☐ Fax (____) _______ - _________

☐ Scan and e-mail attachment: (e-mail address) ________________________________________

Print Instructor Name: ______________________________________________________________

Instructor Signature: ___________________________________________ Date: ________________