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TEST REQUEST FORM
ADVISING AND TESTING CENTER ~ 724-357-4067 ~ Room 216 PRATT HALL

MUST BE COMPLETED BY THE STUDENT FULLY TO PROCESS: PROFESSOR'S INFORMATION MUST BE FULLY COMPLETED ON THE BACK

THIS FORM MUST BE SUBMITTED THREE WORKING DAYS BEFORE THE TESTING DATE. FOR FINALS PLEASE SUBMIT FORM ONE WEEK BEFORE TESTING DATE.

The Advising and Testing Center's operating hours are from 8:00 am to 4:30 pm Monday – Friday.

If your schedule requires you to take the exam outside of these business hours please make SPECIAL arrangements to do so.

Please be sure to take into consideration your extended time when choosing a time.

Date Submitted:_____ Student's Name:_____

Student's Phone Number:_____Student's Email:_____

Instructor's FULL Name:_____ Phone Number:_____

Instructor's Email:_____ Class:_____-_____-_____ (ex. PSYC 101-001)

Date & Time you wish to take the exam:

1st Choice: Mon Tues Wed Thur Fri Month:_____Date:_____Time:_____

2nd Choice: Mon Tues Wed Thur Fri Month:_____Date:_____Time:_____

What type of non-standard testing will you require?

Extended Time _____ Reader _____ Transcribed_____ Computer Use _____

What type of exam setting will you need?

Semi Quiet (Potential External Noise) _____ Quiet _____ Extremely Quiet (As Little Noise as Possible) _____

PLEASE CHOOSE ONE OF THE FOLLOWING TWO OPTIONS

1. **_____ Please check here if you are uncomfortable with sharing a proctor with another student, Understand that you will have your own testing area and the other student will not be visible.**
2. **_____ Please check here if you don't mind sharing a proctor.**

Other/Special Instructions: _____

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BE SURE TO HAVE YOUR PROFESSOR COMPLETE BACK OF FORM

TO BE COMPLETED BY ADVISING AND TESTING CENTER			
	Assign Number		Assign Room:
	Send Out Proctor Email Request		Put on Google Calendar
	Assign Proctor:_____		Receive Test
	Send Email Confirmation to Professor, Student & Proctor		Test Delivered

MUST BE COMPLETED BY THE PROFESSOR FULLY TO PROCESS UPON COMPLETION OF THE FRONT BY THE STUDENT

Department Location:_____

(If the completed exam is being delivered back to you by our ADVT this location is where it will be hand delivered)

Department Phone Number:_____

Professor's Signature: _____

By signing this form you are authorizing approval for the student's requested exam times on the front side of this form.

NORMAL CLASS TIME allotted TO COMPLETE EXAM: _____

This is used to calculate the student's extended test time and MUST be indicated

Please indicate below in which way the exam will be delivered (MUST CHOOSE ONE)

1) _____ Hand delivered by the professor

2) _____ Emailed as attachment to dss-test@iup.edu

3) _____ FAX to (724- 357-2889) Advising and Testing Center

4) _____ Advising and Testing Center pick up exam

If the Advising and Testing Center is to pick up the exam, we will do so at the professor's departmental office from the secretary. If the student is taking the exam in the A.M., the exam will have to be picked up by the afternoon before the testing date. If the student is taking the exam in the P.M., the exam will have to be picked up by the morning of the testing date.

Date: _____ A.M. ____ P.M. _____

_____ Please check here if you want to pick the exam up from The Advising and Testing Center.

SPECIAL INSTRUCTIONS:_____

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