

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: _____

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**

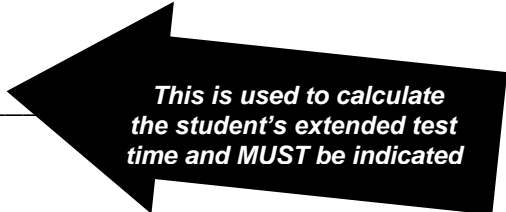
Department Location: _____
(If the completed exam is being delivered back to you by our ADVT this location is where it will be hand delivered)

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: _____



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: _____

