

Testing Center Exam/Quiz/Finals Schedule Form

***** To Be Filled Out By Student in pen or typed *****

Student's Name: _____ UIN: _____00_____

Course Information:

Course & Section #: _____

Class Day(s) & Time: _____

Class Location (Bldg. & Rm.): _____

Contact Information:

Instructor: _____

Instructor's Phone #: _____

Instructor's Email: _____

***** Every exam must be initialed by instructor in pen or typed *****

**Testing Center (TC) Hours: Monday – Thursday 8:00am – 6:00pm, Friday 8:00am –

5:00pm** After Hours Dependent on Staff Availability

Exam/Quiz Date to be administered in the TC <i>Ex: 9/6/2024</i>	Exam Time to be administered in the TC <i>Ex: 2:00 PM</i>	Exam Length In Classroom <i>Ex: 50 minutes</i>	Same date as rest of class for the exam? <i>Ex: Yes/No</i>	Same time as rest of class for the exam? <i>Ex: Yes/No</i>	Instructor Initials (required) <i>Ex: JH</i>

Office Use Only: Student was informed of final exam scheduling deadline and chose not to schedule final _____
Student was informed of TC hours and finals prep days for scheduling purposes _____

Special Testing Needs: If you have been approved for and need equipment, software or a special accommodation, please check all that apply:

Scribe _____ Reader _____ Other (specify): _____

Computer Needs (Required Software/Accommodation - Word, Excel, Internet Access, etc): _____

***** Instructor must sign below and initial each exam above*****

I have met with the above named student and received the notification of his/her registration with Disability Resources (DR). I am aware that this student is requesting testing accommodations in the Testing Center (TC), and I agree with this schedule.

Instructor's Signature

Date

Received by:

Initials: _____
Date: _____
Time: _____