Testing Accommodation Form

Completed form MUST be submitted by the student to the SSD Lab (L115) NO LATER than two days before the exam in order to guarantee accommodations.

STUDENT USE ONLY- Please return completed form to L115

Student Name: __________________________ Course: __________________________
Phone number: __________________________ Professor: __________________________

Classroom Exam Location: ______________ Date: ______________ Time: ______________

This is an official request to take the above stated exam with accommodations under Section 504 of the Rehabilitation Act of 1973 and the American with Disabilities Act as amended 2009. I agree to follow the procedures arranged by SSD, and to uphold QCC’S policy on academic integrity pertaining to this exam.

X
Signature of Student
Date

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PROFESSOR USE ONLY - Please complete and return form to student
(Remember to ask to see the students QCC SSD Accommodations Card)

1. How much time do you provide the CLASS for this exam/quiz? Hours: _____ Minutes: _____

2. ALL students are allowed the following materials and/or tools for this class exam (please fill in) __________________________________________________________________________

3. Please complete only if you agree to an alternate date and time from class taking exam:
   Alternate date and time Date: ________________ Time: ________________

4. Please confirm how SSD will receive exam in advance of class time:
   _____ Exam will be emailed to SSDexams@qcc.cuny.edu - preferred method
   _____ Exam will be dropped off: (Please circle one) S-132  L-115
   _____ Exam will be left in bldg-room _______________________________________________________________________

By signing I agree to have Services for Students with Disabilities administer the above exam with accommodations for this student

Signature of Professor: __________________________ Phone: __________________________

please print Professor name: __________________________________________________________________________

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Signature of person receiving returned exam: __________________________ Date: ____________
SSD AUTHORIZATION (SSD Staff use only)

Time exam started if not as scheduled: ____________________________________
(Indicate time, initial)

Authorize by initialing services (and indicate name of reader or scribe):

Scribe: ________________________ / ________________________ (Name of scribe)
(Initial) Calculator Use: _____ CCTV: _____

Reader: ________________________ / ________________________ (Name of reader)
(Initial) Enlarged Print: _____ Audio: _____

Specialized Location (Other than L115): ________________________

Computer use: _________________________________________________
(Indicate program used, initial)

OTHER/COMMENTS SECTION

Other Materials Included with returned exam: ________________________

Comments: _______________________________________________________

__________________________

INITIAL if completed exam photocopied for L115 file: _______

SSD STAFF USE ONLY – Exam Return Confirmation

INITIAL Contents Enclosed:

Exam: _______ Scantron: _______ Blue Book: _______ Answer Sheet: _______

Authorized Scrap Paper: _______ Printed Responses: _______ Other/Comments: _______(see above)

Delivered to professor mailbox by: __________ Exam picked up by professor: __________
(Initial) (Initial)

Date of Exam Return: _______________ Location: _______________ Delivered by: _______
(Initial)