DISABILITY SUPPORT SERVICES
TESTING ACCOMMODATION REQUEST FORM

STUDENT INFORMATION:

STUDENT LAST NAME	STUDENT FIRST NAME	ID #

_____ @COUGARS.CSUSM.EDU _____
STUDENT EMAIL   CONTACT PHONE

_____ _____ DAYS/TIMES OF CLASS MEETING: _____ AM | PM
CLASS (EX: ASTR 342) LOCATION (EX: MARK 337)

CLASS INSTRUCTOR INFORMATION:

_____ @CSUSM.EDU
INSTRUCTOR NAME   INSTRUCTOR EMAIL

_____ _____
SUPPORT STAFF & SUPPORT STAFF EXTENSION   AVAILABLE CONTACT INFO FOR DSS TO REACH IF AN EXAM QUESTION ARISES

EXAM RETURN DELIVERY METHOD: (to ensure receipt of exam, please check appropriate box below)

☐ **EMAIL & PICK UP**	☐ **EMAIL & DELIVER**	☐ **PICK UP**	☐ **DELIVER**
DSS STAFF WILL SCAN/EMAIL COMPLETED EXAM. PROFESSOR WILL PICK UP HARD COPY, CRAVEN 4200	DSS STAFF WILL SCAN/EMAIL COMPLETED EXAM. HARD COPY WILL BE DELIVERED TO SUPPORT STAFF	PROFESSOR/SUPPORT STAFF WILL PICK UP IN CRAVEN 4200	STUDENT ASSISTANT WILL DELIVER TO PROFESSOR/ SUPPORT STAFF

PROFESSOR DIRECTIONS FOR QUIZZES, EXAMS, AND MIDTERMS: (may continue on backside)

DATE OF EXAM/QUIZ	DIRECTIONS (AIDS, CALC, OPEN BOOK, NO NOTES, ETC.)	EXAM LENGTH FOR CLASS

STUDENTS WHO REQUEST TO TAKE AN EXAM/QUIZ OUTSIDE OF REGULAR CLASS TIME MUST RECEIVE WRITTEN PERMISSION. IF YOUR STUDENT IS PERMITTED TO TEST OUTSIDE OF CLASS TIME, PLEASE INDICATE BELOW (APPLICABLE FOR THE ENTIRE SEMESTER).

☐ MY STUDENT **HAS** PERMISSION TO TEST OUTSIDE OF REGULAR CLASS TIME

☐ MY STUDENT **HAS** PERMISSION TO TEST OUTSIDE OF REGULAR CLASS TIME, *BUT WITHIN*: _____

☐ IF NEEDED, MY STUDENT **MUST REQUEST** PERMISSION PRIOR TO <u>EACH</u> EXAM

CLASS FINAL EXAM DATE & TIME: _____

DIRECTIONS: _____
_____