Test Proctoring Form for the Disability Services Office

5 days advance notice is needed to schedule a proctor and room

Questions? Contact Dr. Michelle Blakely at: mblakely@truman.edu, 660.785.4478.

STUDENT INFORMATION

Student's Name: _____ Banner ID: _____

I agree to comply with all proctor policies and procedures for test proctoring. I understand that failure to do so may result in losing the privilege of using the proctoring services. I understand that the test will not be administered if my arrival time is 15 minutes after the instructor's stated start time. However, if I am late and within the 15-minute window, I understand the amount of time I am late will be deducted from the total time allowed for the test. I agree to abide by Truman State University's Academic Dishonesty Policy and I understand that any violation of this policy will be reported to the Professor of record.

Currently, my test accommodations include: ___ time and a half ___ double time ___ quiet distraction free room

____ other, please list _____ Email: _____

Signature: _____ Date: _____

FACULTY INFORMATION

Instructor's Name: _____ Course/Section: _____

Phone #: _____ Email: _____

Office Address: _____

Date Student Will Take Test: _____

Start Time for Test: _____ Total Time Allowed for Test (Included Extended Time): _____

INITIAL all allowable instruments/alternate format/accommodations:

____None ____ Formula/Tables ____ Calculator ____ Open Book

____ Open Notes ____ Scratch Paper ____Computer

____ Assistive Tech (Dragon Naturally Speaking, Jaws)

Additional Approved Materials/Special Instructions: _____

_____

Test Delivery Information: (Please Check One)

____ Test will be hand delivered to the Disability Services Office in the Student Health Center by 11:30am the day before the test.

(The doors are locked from 11:30am-12:30pm for lunch).

____ Test will be emailed to mblakely@truman.edu by 12pm (Noon) the day before the test.

Signature: _____ Date: _____

DSO Staff Only:

Time Started: _____ Staff Initials: _____ Time Ended: _____ Staff Initials: _____

Test Returned To:_____ Date/Time: _____

(**Signature Required** of Person taking Possession of Completed Test from DSO Staff)

DSO Staff Signature: _____

updated 1/13/2016