Student Success Center

Make-up Test Request Form

SEMESTER:_____________

TO BE COMPLETED BY INSTRUCTOR:

INSTRUCTOR:________________________ DEPT._____________________
CLASS:____________________________
STUDENT TAKING TEST:____________________________
ID #_______________ TEST DATE:_____________________
TEST TIME: FROM:____________TO:____________

- WHAT MATERIALS MAY THE STUDENT USE DURING THE TEST: (PLEASE LIST)

- INSTRUCTIONS FOR ADMINISTERING TEST:

INSTRUCTOR PICK-UP TIME:
DATE:___________ TIME:_____________

TO BE COMPLETED BY STUDENT AT THE TIME OF TESTING:

STUDENT NAME:____________________________
DATE:___________ STARTING TIME:___________ FINISHING TIME:___________

TO BE COMPLETED BY SCC STAFF:

ADMINISTRATOR’S DECISION TO STOP TEST:
TIME:_____________ REASON:_________________________________
DATE ACTUALLY TAKEN:__________STARTING TIME:__________FINISHING TIME:__________
STAFF SIGNATURE:_________________________________________
INSTRUCTOR’S INITIALS:___________DATE PICKED UP:____________