Test Scheduling Form

Office: 208-732-6260 / Secure Fax: 208-732-6799

CSI STUDENT ACCESSIBILITY SERVICES

Student Name: _____   Today's Date: _____

Student ID #: _____

> **Please schedule request ASAP**
> *preferably 1-2 weeks ahead*

Step 1

Best way to contact me:

☐ Cell Phone: _____   ○Call ○Text   ☐ Home Phone: _____

☐ Email: _____

Step 2

Test Accommodation(s) being requested (*Please select ALL that apply*):

☐ Separate Testing Room   ☐ Extended Time   ☐ Reader   ☐ Scribe   ☐ CCTV

Class Information:

**FULL Class Name: _____   Course Code: _____

Instructor's **FIRST** Name: _____   **LAST** Name: _____

Type of Test: ☐ Paper and Pencil Test   OR   ☐ Computer Test

Step 3

Date and Time Choices:

1st Choice **Date**: Month _____ Day _____   **and**   Start **Time**: _____ AM/PM **&** End **Time**: _____ AM/PM

2nd Choice **Date**: Month _____ Day _____   **and**   Start **Time**: _____ AM/PM **&** End **Time**: _____ AM/PM

3rd Choice **Date**: Month _____ Day _____   **and**   Start **Time**: _____ AM/PM **&** End **Time**: _____ AM/PM

**Total Length of Time for Testing (including extended time): _____

Testing Location: ☐ Testing Center   OR   ☐ Other: _____

Additional comments: _____

FOR OFFICE USE ONLY:
Provider (○Reader/○Scribe): _____
Confirmed with Testing Center: _____ (Date): _____
Confirmed with Student: _____ (Date): _____

**To insure timely and accurate scheduling, student must *THOROUGHLY* and *CORRECTLY* complete this form.