

PROCTOR REQUEST FORM

Confidential

Office for Students with Disabilities

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The STUDENT AND PROFESSOR/INSTRUCTOR SECTIONS of this form must be completed **BEFORE** services are provided. This form must be turned into the OSD Testing Center at least **3 business days** before the class scheduled test/exam date.

Name:		UTC E-mail Address:		Phone Number:		Course Title/Number:	
Please note: You are expected to take the test when indicated by your professor. You must get approval from your professor to change the scheduled exam time.							
Professor or Instructor must complete this section in its entirety. Please print clearly.							
Professor Name:		UTC E-mail Address:			Course Title/Number:		
Office Phone Number:				Department Phone Number:			
Exam information		Exam length for class	Test Aids Permitted (calculator, tables, etc.)	Indicate how OSD will obtain exam	Where to pick up and /or deliver exam	Professor Signature	
Test #1	Test #2	#1:		Email	Fax	Building:	
Date:	Date:			Pick-Up	Deliver	Room:	
Test #3	Test #4	#3:		Email	Fax	Building:	
Date:	Date:	#4:		Pick-up	Deliver	Room:	
Test #5	Test #6	#5:		Email	Fax	Building:	
Date:	Date:	#6:		Pick-up	Deliver	Room:	
Time:	Time:						
Comments:							

-----Do Not Write Below This Line-----For OSD Use Only-----

Accommodations:

Extended Time: 1.5 2
 CCTV
 Use of AT: Kurzweill Jaws ZoomText Dragon

Reader/Scribe
 Use of spell check/grammar check
 Other: