

TESTING ACCOMMODATIONS FORM

Support Services For Students And Employees With Disabilities
Room # 112 B. F. Roberts Hall
P.O. Box 17156
Jackson, MS 39217
601.979.3704 (telephone)// 601.979.6918 (Fax)// 601.979.6919 (TTY)
Website: <http://ccaix.jsums.edu/ada/>

**THE STUDENT SHOULD COMPLETE THIS SECTION:
(Further assistance may be provided upon request)**

Student's Name (Print): _____

Social Security Number: _____

Course Department: _____ Course Number _____ Section: _____

Instructor's Name _____

List accommodations needed for this test: _____

I understand that only by submitting this form to the ADA Coordinator 1(one) week before the test date listed below I will guarantee myself the accommodations specified on the Testing Accommodations Form signed by me and on file in the ADA Office. I further understand my failure to appear for testing within 15 minutes of the test time will result in the forfeiture of my scheduled testing time and the return of the test to the instructor.

(Note: Upon the successful completion of the TESTING ACCOMMODATIONS FORM, it will remain as an official document in the Office of Support Services For Students And Employees With Disabilities.)

Student's Signature _____ ***Date*** _____

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THE INSTRUCTOR SHOULD COMPLETE THIS SECTION:

Date test was announced to the class: _____ Date test will be delivered to
class: _____ Time: _____

Time which will be allotted for test in regular classroom: _____

Special instructions (e.g., open book, calculator, or notes allowed, etc.): _____

Method of delivery: _____ instructor _____ departmental representative ___ ADA ___

**(Note: The ADA Coordinator relies on you to deliver the test to the ADA Office, in
emergency situations, The ADA Coordinator or an official representative will pickup
the test(s). ___ADA Pick-up time: _____ Pick up
location _____)**

Instructor's Signature _____ Date _____

Date Form received by the ADA Office _____ Time _____

Date Test received by the ADA Office _____ Time _____

Date Test Administered _____ Time begun _____ Time ended _____

Total time spent on test _____ Proctor's initials _____

Test returned to department _____
Who delivered test _____ Date _____ Time _____

Dept. Rep. Signature _____