

COVER SHEET FOR MAKE-UP EXAMS

Testing Center at Kent State Stark
Academic Success Center | 40 Campus Center
Ext. 55040 | Ext. 55050 | Ext. 55060
Email: starktesting@kent.edu
www.kent.edu/stark/testing-services

TO: Testing Center

FACULTY NAME: _____ OFFICE/BUILDING: _____ EXT: _____

DATE TEST SENT: _____ DEPT & COURSE #: _____

MAKE-UP TEST DATE:

_____ Student must take the exam _____ (time/date).

_____ Student may take the exam any time the Testing Center is open on a walk-in basis not to exceed:
_____ (time/date).

PLEASE NOTE: The Testing Center will firmly honor your deadline unless we hear from you by email or phone. Please do not send word with a student regarding deadline changes.

NAME OF STUDENT(S): _____

REGULAR CLASS TIME allowed for test: (check one) 50 min. 75 min. Other _____

SAS will determine the total testing time based on the individual student's accommodations.

AIDS PERMITTED: Please check all aids allowed for this exam:

_____ calculator (circle type) basic/scientific/graphing _____ scrap paper (provided, not provided)
_____ textbook _____ notes
_____ charts, graphs, tables _____ other (please explain)

EXTRA TESTS: I have included _____ extra tests for any student not listed by name.

COMPLETED TEST INSTRUCTIONS:

_____ SCAN and SHRED test (tests will be held for a brief security period)

_____ SCAN and HOLD test for me to pick up

OTHER SPECIAL INSTRUCTIONS: _____

View Testing Center hours at www.kent.edu/stark/testing-services.