



CENTER FOR ACADEMIC & STUDENT SUCCESS
DISABILITY SUPPORT SERVICES
25 Journal Square, Jersey City, NJ 07306, 201-360-4157

TESTING ACCOMODATION REQUEST FORM

Student Name: _____ ID # _____
Phone Number: _____ Email Address: _____

Class Name: _____
Exam Date: _____ Time: _____
Professor: _____
Professor's Email: _____
Professor's Phone: _____

___ Student will be given extra time in class for exam
___ Student has my permission to take the exam in the Disability Support Service Office.

Special Instructions:

Professor's Signature: _____

Class Name: _____
Exam Date: _____ Time: _____
Professor: _____
Professor's Email: _____
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Professor's Signature: _____

Student Signature: _____ Date: _____