CONFIDENTIAL
ALTERNATIVE TEST AGREEMENT FORM
Office of Disability Services
Minnesota State University, Mankato • 389-2825 (V/TTY)
Alternative Test Coordinator • 389-2825

Term: ___________________ Course Title: ____________________________________
(Semester/year)

SECTION 1: Student
Name: Jane Doe Phone: 389-0000 Tech ID: 0012345
Course Title: Psychology Course # 101 Section # 2
Instructor’s Name: Jack Smith Department: Psychology
Instructor’s Office #: AH 222 Instructor’s Phone #: 389-1111

SECTION 2: Director of Disability Services
This student qualifies for alternative testing because of:
____ Documentation of disability

Accommodations approved through the Office Disability Services
____ Distraction-free environment ____ Extended time ____ Test scribe
____ Test reader/audio tape ____ Word Processor ____ Calculator
____ Other (please specify) ___________________________________________

Director of Disability Services signature __________________________ Date ______

SECTION 3: Instructor
This student has requested alternative testing accommodations for the reason(s) noted above. Please complete Section 3 and return promptly to Disability Services at least three days prior to the first test date. Please note that tests are administered M – F from 7:30 A.M. – 4:30 P.M.

The student may use: ___ books ___ notes ___ calculator
___ formulas/tables ___ dictionary ___ data sheet
___ other material (please specify) _______________________________________

TEST PICK UP: Disability Services Staff will pick up the test from the department office at after 2:00 P.M. the day prior to the test date.

TEST DELIVERY: The completed test will be delivered by 9:00 A.M. the next day to the department office.

Instructor’s signature __________________________ Date ___________