



ACCESSIBLE STANDARDIZED TESTING REQUEST

Name: _____ Anticipated Test Date: _____

Net ID: _____ Cal State East Bay Student: Yes No

Phone: _____ Email: _____

Test Name: _____

STUDENT

Upon discussing my accommodation needs with an accessibility counselor, I authorize Accessibility Services and the University Testing Office to communicate regarding my accommodations for the above standardized exam.

STUDENT'S SIGNATURE PARENT | GUARDIAN'S SIGNATURE (IF STUDENT IS UNDER 18) DATE

FOR ACCESSIBILITY SERVICES USE ONLY

Accommodations Approved by Accessibility Services:

Four horizontal lines for listing accommodations.

Accessibility Counselor:

I have approved the above accommodations based on the student's disability and corresponding functional limitations. The student is eligible for the above accommodations under Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and amendments of 2008.

COUNSELOR'S NAME (PRINTED) COUNSELOR'S SIGNATURE DATE