Attachment A

Request to Take ACCUPLACER® at a Remote Location

Student’s Name: ____________________________________________________________

Student ID#: ___________________________

Address: ________________________________________________________________

City, State, Zip: _____________________, ________________________________

E-mail: _________________________________________________________________

Phone #: (_____)(_____)-___________

Please fill out the following information regarding the proctor who has agreed to administer/proctor the ACCUPLACER tests to you. It must be someone from a test center at an academic institution. (All sections must be filled in!)

Proctor’s Name: __________________________________________________________

Institution: ______________________________________________________________

Mailing Address: _________________________________________________________

City, State, Zip: _____________________, _________ _________

Phone: (_____)(_____)-___________ Fax: (_____)(_____)-___________

E-mail: _________________________________________________________________

Please fill out the above form and return to:
Bob Watson
Assessment Testing Supervisor
505.224.4000 ext. 52015

Fax: 505-224-3258