Authorization for Release of Test Scores

Please print:

Name: _____
Last First MI Name when test was taken (if different)

Student ID Number: 7 7 7 0 _ _ _ _ _

Phone: _____ Date of Birth: _____

Email: _____

Test Name (mark one):
__ COMPASS __ Accuplacer __ TEAS __ Other (_____)

Approximate month and year test was taken: _____

Destination to where the test scores are to be sent (only one option is required):

Email: _____ Fax: _____

Address: _____
_____

I hereby authorize the Testing Center at South Arkansas Community College to release my test scores to the destination indicated above.

Signature: _____ Date: _____

There is no charge for this service. Scan and send this request to testing@southark.edu or fax to 870-875-7296.

SOUTHARK
South Arkansas Community College