



## Test Score Release Authorization

(Accuplacer only)

**Please Print:**

Requestor's First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

UALR "T" number **T** \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/dd/yy

Address/P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

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I hereby authorize the University of Arkansas at Little Rock, Testing Services to release my **Accuplacer** test score results to the following person, agency, service, or institution:

Name \_\_\_\_\_ Agency/Institution \_\_\_\_\_

Department \_\_\_\_\_ Address/P.O. Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Fax# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

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Requestor's Signature \_\_\_\_\_ Date Submitted: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/dd/yy

Send this completed form to:

Testing Services  
University of Arkansas at Little Rock  
2801 South University Avenue  
Student Services Center, room 315  
Little Rock, Arkansas 72204

Fax: 501.569.8096

Email: [proctor@ualr.edu](mailto:proctor@ualr.edu)