Test Score Release Authorization

Please Print:

Requestor's First Name_____ Middle Initial _____Last Name _____

UA Little Rock "T" number**T**___ ___ ___ ___ ___ ___ ___ ___ Date of Birth ___ ___/___ ___/____ ___ mm/dd/yy

Address/P.O. Box_____City _____State_____Zip_____

Phone# (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Email: _____ @ _____

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 _____

Institution/Department Address/P.O. Box _____

Institution City_____State _____Zip_____

Institution Fax# (__ __ __) __ __ __-__ __ __ __ Phone# (__ __ __) __ __ __-__ __ __ __

Institution Email: _____ @ _____

Important: You must attach/upload a picture of your photo ID.

Requestor's Signature_____ Date Submitted: ___ ___/___ ___/___ ___
mm/dd/yy

Send this completed form and a picture of your photo ID to:

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

Fax: 501.916.3096 Email: proctor@ualr.edu