LEHMAN COLLEGE

The City University of New York

Student Disability Services
Exam Request Form

Student Name: _____   EMPL ID: _____

Email: _____   Cell #: _____

Course Name / Section *(Example: LEH 101 – S01)*: _____

Professor's Name: _____

Professor's Email: _____

Date of Exam: _____   Time of Exam: _____ ☐AM / ☐PM

  *I have a class immediately before this class ☐ Yes ☐ No

  *I have a class immediately after this class ☐ Yes ☐ No

If you answered yes to either or both above, when would you like to take your exam? Please note the hours of the SDS office are Monday through Friday, 9:00 AM to 5:00 PM:

_____

_____

Please complete and submit this to
Disability.Services@Lehman.cuny.edu