

STUDENT RE-EXAMINATION FORM REQUEST

 *Form must be completed and signed by ALL parties prior to submittal to
The Office of Enrollment Services* 

1. Name of Exam Failed: _____
Name of Exam Retaking (If differs): _____
Date of Scheduled Exam: _____
Exam Registration Fee: **\$50.00**

2. Student Pin Number: _____
Legal Name of Student: _____

Signature of Student Dated

3. College: _____
Program: _____
Academic Major: _____
Grade Term of which exam was taken: _____

As authorized by our signatures below, we do hereby give permission to the student referenced above to retake said exam mentioned herein, ***as so stated in The University of Tennessee Health Science Center CenterScope, of the Academic Process, Requirements for Graduation, Grades.***

Requesting signature of Associate Professor Dated

Signature of Department Chair Dated

Signature of Department Dean Dated