

**REQUEST FOR AUTHORIZATION TO ACCESS/BORROW
CIMC RESTRICTED TESTS**

Please write legibly and fill out completely. Thanks!

Date of Request: _____

Requestor's Name: _____

Requestor's Title: _____

State of Wisconsin Psychologist/Psychiatrist License No.: _____
(required for University Faculty and Staff not in the School of Education)

Period of Authorization: _____
(not to exceed a single academic term or break period)

Suggested Circulation Period: _____
(maximum of three days)

Signature of Authorizing Party: _____

Name of Borrower: _____

Name of Test: _____

CIMC STAFF USE ONLY

Date request received: _____

Staff member initials: _____

Request granted: Yes _____ No: _____