



Academic Programs Office
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REQUEST TO VIEW AN EXAM

****FORM MUST BE COMPLETED IN FULL TO BE APPROVED****

STUDENT NUMBER

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LEGAL LAST NAME	INITIALS	GIVEN NAMES	SEX
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ADDRESS INFORMATION	MCMASTER E-MAIL:
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APT. / STREET	CITY	PROVINCE	POSTAL CODE
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HOME TELEPHONE		CELLULAR	
AREA		AREA	

COURSE NAME & CODE:	
INSTRUCTOR:	
<input type="checkbox"/> Fall <input type="checkbox"/> Winter (must be submitted by June 30 following the Fall/Winter Session)	REASON FOR REQUEST:
<input type="checkbox"/> Spring/Summer (must be submitted by October 15 following the Spring/Summer Session)	

Please continue on separate page if need be. Thank you.

Student Signature: _____ **Date:** _____

Approval of APO: _____

CONFIRMATION THAT THE EXAM HAS BEEN VIEWED:

Student Signature: _____ **Date:** _____

Professor/appointee Signature: _____

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