SCHOOL / GROUP LIST

(Please photocopy and distribute as needed)

District Name: _____

School Name: _____

Contact Person: _____

Address: _____

Town/Province: _____

Postal Code: _____

Telephone: _____

Testing Completed: ____ / ____ / ____

month day year

Please check the appropriate box:

☐ CAT·4 ☐ CAT·3

☐ Insight ☐ CTCS

☐ Other (please specify) _____

Please return completed test documents to:

CTC/Canadian Test Centre
80 Citizen Court, Suite 10
Markham, ON L6G 1A7
1-800-668-1006

Teacher Name (or Group Designation)	**Grade**	**Test Level**	**# of Students Tested**	**Comments**
Total				

CTC use only. Please do not write below this line.

Special Information	Order Number
	School Number

Photocopy completed form and send one copy with order and keep one for your files.

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