

UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER GRADUATE SCHOOL

REQUEST FOR SCHEDULING EXAM

THIS FORM IS DUE **AT LEAST** TWO WEEKS PRIOR TO THE DATE OF THE EXAMINATION. SEE **INSTRUCTIONS SHEET** FOR INFORMATION ON FILLING OUT THIS FORM.

STUDENT NAME: _____ STUDENT# _____

DEPARTMENT OR SCHOOL: _____

TYPE OF EXAMINATION: (check one):
 Master of Science
 Ph.D. Comprehensive

DATE OF EXAM (mm/dd/yy): _____ TIME: _____ ROOM NUMBER: _____

THESIS TITLE (if M.S.-Plan I):

THESIS ADVISOR or MENTOR (if known, all PhD's and MS thesis): _____

EXAMINATION COMMITTEE (print or type names; no signatures):

FACULTY NAME

PROGRAM AFFILIATION

Chair: _____

Other Members: _____

REQUIRED APPROVAL SIGNATURE:

BASIC SCIENCE STUDENTS- Graduate Program Director
NURSING STUDENTS- MS - Dr. Victoria Erickson & PhD - Dr. Kathy Magilvy

Date

RETURN THIS FORM **AFTER** PROGRAM APPROVAL TO: GRADUATE SCHOOL, BOX C296 OR DENISON AUDITORIUM
BLDG, ROOM 1D01. CALL 303-315-7928 IF YOU HAVE ANY QUESTIONS.

(EXAM.FRM/0607)