Colorado School of Public Health

REQUEST FOR SCHEDULING DrPH EXAM

THIS FORM IS DUE **AT LEAST** TWO WEEKS PRIOR TO THE DATE OF THE EXAMINATION.

STUDENT NAME:____ **STUDENT#**______________________

DEPARTMENT:____

TYPE OF EXAMINATION (check one): DrPH Comprehensive Exam DrPH Dissertation Defense

Written

Oral

DATE OF EXAM (mm/dd/yy):__________________ **TIME**:____________ **ROOM NUMBER**:______________

DISSERTATION TITLE

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DISSERTATION ADVISOR or MENTOR:_______________________________________

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

	FACULTY NAME	PROGRAM AFFILIATION
Chair:		
Other Members:		

REQUIRED APPROVAL SIGNATURE:

____ ___________

Committee Chair Date

____ ___________

Program Director Date

RETURN THIS FORM AFTER PROGRAM APPROVAL TO: Colorado School of Public Health, Academic Affairs