**UNIVERSITY OF COLORADO DENVER**
**Colorado School of Public Health**

# 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**:______________________________________________

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

**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**