Request to Schedule M.A. Exam

Name: ______________________ **UIN:** ______________________

Local Address: ______________________ **Email:** ______________________

Department: ______________________ **Curriculum:** ______________________

*****Please check the exam you are scheduling and complete the information requested for that exam*****

☐ **M.A. Exam – Written**

Date:	Time:	Exam Topic:	Examiner:	Grader(s):

☐ **M.A. Thesis Defense – Oral – Thesis deposit required**

Date:	Time:	Room:	Dissertation Title: **(IMPORTANT)**

Committee Member: ______________________ Phone Number: ______________________

*********PLEASE COMPLETE THE FOLLOWING INFORMATION ********

	Committee	**Department:**	**Area of Specialization**	**Graduate Faculty** Y or N	**Tenured** Y or N
Chair:					
Member:					
Member:					
Member:					
Member:					

REQUIRED SIGNATURES:
Department Director of Graduate Studies (DGS) - ______________________

The Examiner is responsible for submitting the exams 72 hours before each scheduled exam.