

Copies to: Registrar
Dean
Department
Guidance Committee
Student

RECORD OF COMPREHENSIVE EXAMINATIONS
for
DOCTORAL DEGREE AND EDUCATIONAL
SPECIALIST DEGREE CANDIDATES

Check if this is a re-examination because of expired time limits.

Department of _____

Student's Name _____ Student Number _____
Last, First Middle Initial

Term and Year of First Course Counted towards this Degree _____

Result of Written Comprehensive Examinations:

<u>Field</u>	<u>Examiner(s)</u>	<u>Examination Date (MM-DD-YY)</u>	<u>Passed or Failed</u>
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Result of Oral Comprehensive Examinations:

<u>Field</u>	<u>Examiner(s)</u>	<u>Examination Date (MM-DD-YY)</u>	<u>Passed or Failed</u>
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OVERALL PASS or FAIL? _____

Signed _____ Date _____
Chairperson of Examination Committee

Signed _____ Date _____
Chairperson of Department

Signed _____ Date _____
Dean of College