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): _______

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: ____________ Member: ____________

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

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