Completion of Requirements for Oral Comprehensive Exam

Department of Pharmacology
Graduate Program

(Name of Student) ______________________ **(Degree)** ______________________

(Major Advisor) ______________________ **(Date of Selection)** ______________________

(Co-Advisor, if applicable) ______________________

Approval of Passing Oral Comprehensive Examination:

Committee Member: ______________________ **Date:** __________

Committee Member: ______________________ **Date:** __________

Committee Member: ______________________ **Date:** __________

Committee Member: ______________________ **Date:** __________

Committee Member: ______________________ **Date:** __________

Student's Signature: ______________________ **Date:** __________

Major Advisor's Signature: ______________________ **Date:** __________

Original to: Director of Graduate Studies, Pharmacology