

DISSERTATION EXAMINATION INFORMATION

* Please return to the Division of Medical Sciences 4 weeks prior to date of dissertation defense.

Name of Candidate: _____ Phone No.: _____

Phonetic Pronunciation of Name: _____

SEMINAR:	SEMINAR LOCATION (Complete mailing address):
Date: _____	Institution: _____
Time: _____	Building & Room #: _____
	Street Address: _____
	City, State, Zip: _____
EXAM:	EXAM LOCATION (Complete mailing address):
Date: _____	Institution: _____
Time: _____	Building & Room #: _____
	Street Address: _____
	City, State, Zip: _____

PLEASE PROVIDE FULL ADDRESS, TELEPHONE NUMBER & EMAIL OF EXAMINERS AND CHAIR.

EXAMINER 1:	Name: _____
Phone: _____	Institution: _____
Cell (mandatory): _____	Building: _____ Room #: _____
Email: _____	Street Address: _____
	City, State, Zip: _____
EXAMINER 2:	Name: _____
Phone: _____	Institution: _____
Cell (mandatory): _____	Building: _____ Room #: _____
Email: _____	Street Address: _____
	City, State, Zip: _____
EXAMINER 3 (non-Harvard):	Name: _____
Phone: _____	Institution: _____
Cell (mandatory): _____	Building: _____ Room #: _____
Email: _____	Street Address: _____
	City, State, Zip: _____
Field of Research Interest: (Two Words) _____	
ALTERNATE EXAMINER:	Name: _____
Phone: _____	Institution: _____
Cell (mandatory): _____	Building: _____ Room #: _____
Email: _____	Street Address: _____
	City, State, Zip: _____
CHAIR:	Name: _____
Phone: _____	Institution: _____
Cell (mandatory): _____	Building: _____ Room #: _____
Email: _____	Street Address: _____
	City, State, Zip: _____

**If you have more than one outside examiner, please make sure to include a field of research interest (two words).