**Thesis Oral Defense Application**

**[Submitter]**

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| --- | --- | --- | --- |
| Graduate School | | Program | ( ) Th.M. ( ) Th.M.+Ph.D. ( ) Ph.D. |
| Major |  | Name |  |
| Student ID |  | Contact | CP :  Email : |

**[Thesis Title]**

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This is to certify that above student has successfully completed thesis.

Supervisor: Professor (Signature)

I hereby, request for an oral defense of Spring / Fall semester 20 upon advisor’s recommendation

Year 20 Month Day

Name: (signature)

To Thesis Advisory committee