ARKANSAS TECH UNIVERSITY

REQUEST TO SCHEDULE THESIS DEFENSE

This form should be completed and filed with the Graduate College.

STUDENT NAME: _____ **T NUMBER:** _____

EMAIL ADDRESS: _____ **DATE:** _____

DEPARTMENT/PROGRAM: _____

THESIS TITLE:

DATE OF DEFENSE: _____ **TIME OF DEFENSE:** _____

LOCATION OF DEFENSE: _____ , _____
Building Name Room Number

SIGNATURES OF THESIS COMMITTEE MEMBERS: _____

_____	_____	
CHAIR NAME (PRINT)	SIGNATURE	DATE
_____	_____	_____
COMMITTEE MEMBER (PRINT)	SIGNATURE	DATE
_____	_____	_____
COMMITTEE MEMBER (PRINT)	SIGNATURE	DATE
_____	_____	_____
COMMITTEE MEMBER (PRINT)	SIGNATURE	DATE
_____	_____	_____
COMMITTEE MEMBER (PRINT)	SIGNATURE	DATE

SIGNATURES OF APPROVAL:

_____ _____
Program Director Date

_____ _____
Dean of the Graduate College Date