**Copies to:** Registrar

Dean Department

Guidance Committee

Student

RECORD OF COMPREHENSIVE EXAMINATIONS

for

DOCTORAL DEGREE AND EDUCATIONAL SPECIALIST DEGREE CANDIDATES

Check if this is a re-examination because of expired time limits.

**Department of**

**Student’s Name Student Number**

Last, First Middle Initial

Term and Year of First Course Counted towards this Degree

# Result of Comprehensive Examinations:

**Examination Date**

**Field Examiner(s)**

**(MM-DD-YY) Passed or Failed**

***Comments:***

***OVERALL PASS*** *or* ***FAIL?***

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Professor / Advisor Date

Signed

Chairperson of Examination Committee Date

Signed

Director of Graduate Studies Date

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