



EVALUATION OF THE COMPREHENSIVE EXAMINATION

Chulabhorn Graduate Institute

Semester..... Academic Year

Student Name Mr./Miss/Mrs.....

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Student ID

Program of study.....

Comprehensive Oral Examination Date Time

Venue

① The Comprehensive Examination:

- | | |
|---|---|
| <input type="checkbox"/> Written Examination | <input type="checkbox"/> Passed <input type="checkbox"/> Not Passed |
| <input type="checkbox"/> Oral Examination | <input type="checkbox"/> Passed <input type="checkbox"/> Not Passed |
| <input type="checkbox"/> Other, please specify..... | |
| on date..... | <input type="checkbox"/> Passed <input type="checkbox"/> Not Passed |

② Signatures to acknowledge the evaluation of the Comprehensive Examination Committee

| Position | Prefix First Name – Family Name | Signature / Date |
|--------------------|---------------------------------|------------------|
| Chairperson | | |
| Committee | | |
| Committee | | |
| Committee | | |

Signature.....
(.....)

Chairperson of the Program Management Committee
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