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Chulabhorn Graduate Institute

Academic Support Division
Date Receipt……..
Time……..
Receiver…….

EVALUATION OF THE THESIS PROPOSAL EXAMINATION

Semester……..... **Academic Year** ……......

Student Name (Mr./Ms./Mrs.)……

Program of study……..…

Thesis Advisor's Name…….....

Thesis Co-Advisor's Name (if any)…….....……..

Student ID

☐ Master ☐ Doctoral

Thesis Title (in English) (Use Capital Letters Only)

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Thesis Proposal Examination Date ..... Time .....

Venue .....

① ***The Evaluation by the Thesis Proposal Examination Committee:***

☐ Passed

☐ Passed with conditions (please specify the conditions and time limit. Conditions must be met within 90 days. If there are many conditions, please use additional paper.)

…….……..……..

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☐ Not passed; the student must register to retake the thesis proposal examination on (specify date)

…….……..……..

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② ***Signatures to acknowledge the evaluation of the Thesis Proposal Examination Committee***

Position	**Prefix First Name – Family Name**	**Signature**
Chairperson		
Committee		
Committee		
Committee		
Committee		

Signature……..…….....……

(……)

Chairperson of the Thesis Proposal Examination

Date ……/……/……