**Chulabhorn Graduate Institute**

**EVALUATION OF THE THESIS DEFENSE EXAMINATION**

**(By Committee)**

**Academic Support Division**

Date Receipt……..

Time……..

Receiver……

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

Student Name (Mr./Ms./Mrs.) .....

Program of study ……..…

Thesis Advisor's Name …….....

Thesis Co-Advisor's Name …..…….…….....……..……..

Student ID

☐ Master ☐ Doctoral

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

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Thesis Defense Examination Date …….. Time ..……

Venue .....

① ***The Evaluation by the Thesis Defense 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 examination on (specify date)

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

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

Signature……..…….....…….……

(……)

Chairperson of the Thesis Defense Examination

Date ……..…/……/……..……