STOCKTON UNIVERSITY

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Office of Graduate Studies
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Fall 20___ Spring 20___

STUDENT NAME:_____ STUDENT Z# _____

Total # of Credits Registering for OR Course Number: _____

LOCAL ADDRESS: _____

PHONE: (HOME): _____ (CELL): _____

GRADUATE PROGRAM:_____ E-MAIL:_____

THESIS TOPIC: _____

THESIS COMMITTEE:

CHAIR: _____ _____
Print Name Signature

_____
Title

(2) MEMBERS:_____ _____
Print Name Signature

_____
Title

_____ _____
Print Name Signature

_____
Title

REQUIRED SIGNATURES OF APPROVAL

DIVISIONAL DEAN: _____ _____
Signature Date

DIRECTOR OF GRADUATE STUDIES: _____ _____
Signature Date

Return this original, completed form to the Office of Graduate Studies (F-101)