a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

College of Graduate Studies

This is a retake exam. ☐ **Yes** ☐ **No**

DOCTORAL COMPREHENSIVE EXAMINATION REPORT

This form must be submitted to the College of Graduate Studies once the examination(s) is/are complete.
(please print clearly)

Student Name: _____ **Student #:** _____ **Date:** _____

Faculty: Faculty of Management **Unit (if applicable):** _____

Specialization (if applicable): _____

Results				
☐ **Written Examination**	**Examination Date:**	**Pass** ◯	**Conditional Pass** ◯	**Fail** ◯
☐ **Oral Examination**	**Examination Date:**	**Pass** ◯	**Conditional Pass** ◯	**Fail** ◯
☐ **Other**	**Examination Date:**	**Pass** ◯	**Conditional Pass** ◯	**Fail** ◯
If Conditional Pass, state scope, expected standards and timeline for completion, and identify the faculty member who will relay these requirements to the student:				
If Fail, state reasons:				
If Examination to be repeated, state reasons and set date:				
PLEASE ATTACH ADDITIONAL DOCUMENTATION IF REQUIRED				

Comprehensive Examination Committee	
Supervisor Name:	**Committee Member Name:**
Co-Supervisor Name:	**Committee Member Name:**
Committee Member Name:	**Committee Member Name:**
Committee Member Name:	**Neutral Chair Name:**

Signatures	
Neutral Chair's Signature:	**Date:**
Graduate Program Coordinator's Signature:	**Date:**
NEUTRAL CHAIR TO SUBMIT COMPLETED FORM TO THE COLLEGE OF GRADUATE STUDIES OFFICE (EME 2121)	

For College of Graduate Studies Use Only		
Dean, CoGS (or Designate) Name:	**Signature:**	**Date:**