



Universidad de Puerto Rico, Recinto de Ciencias Medicas
University of Puerto Rico, Medical Sciences Campus

Escuela de Medicina Dental
School of Dental Medicine



Graduate Master's Program / Certificate

APPROVAL OF THE THESIS EVALUATION COMMITTEE / RESEARCH PROJECT

Name: _____ Student ID#: _____

Graduate Program: _____

Title of the Thesis Proposal / Certification: _____

Evaluation Committee:

_____ Name – Principal Advisor	_____ Signature	_____ Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature – Research Coordinator

Day Month Year

Signature – Program Director

Day Month Year

Signature – Assistant Dean of Research

Day Month Year