THE UNIVERSITY OF THE WEST INDIES
School for Graduate Studies and Research

RECOMMENDATIONS FOR THE TITLES AND EXAMINERS
OF THESES AND RESEARCH PAPERS/PROJECTS

CONFIDENTIAL: NOT FOR STUDENT VIEWING

The completed form is to be submitted to the Campus Office of Graduate Studies and Research by the HOD/Graduate Coordinator three (3) months before the final submission of the thesis/research paper/project.

Name of Student: __________________________________________________________________________
(Last name)   (First name)   (Middle Name)

Faculty: _____________________________ Department: ______________________________________

Title of Degree: __________________________________________________________________________

Title of Thesis/Research Paper/Project as approved by the University: ____________________________
_________________________________________________________________________________________

Name/s of Supervisor/Co-Supervisor: ________________________________________________________
_________________________________________________________________________________________

INTERNAL EXAMINERS

Chief Supervisor:
Name: _____________________________ Present Position: _________________________________
Department: ______________________ Fax No.: _________________________________
Faculty: __________________________ Telephone Nos.: ________________________________
Campus: __________________________ Email: _________________________________
Signature*: __________________________

Co- Supervisor:
Name: _____________________________ Present Position: _________________________________
Department: ______________________ Fax No.: _________________________________
Faculty: __________________________ Telephone Nos.: ________________________________
Campus: __________________________ Email: _________________________________
Signature*: __________________________
Internal Examiner (Independent):
Name: __________________________  Present Position: ________________________________
Department: _____________________  Fax No.: ________________________________
Faculty: __________________________  Telephone Nos.: __________________________
Campus: __________________________  Email: ________________________________
Signature*: __________________________

* My signature indicates my responsibility to report on the candidate’s thesis within the specified time allotted:
  1 MONTH - Research Papers/Projects and 2 MONTHS - Theses

EXTERNAL EXAMINERS (Please attach Up-To-Date Curriculum Vitae) ‡
(Names of two (2) examiners are required, one as proxy).

Name: __________________________  Present Position: ________________________________
Mailing Address: ___________________  Fax No.: ________________________________
_________________________________  Telephone Nos.: __________________________
_________________________________  Email: ________________________________

PROXY:
Name: __________________________  Present Position: ________________________________
Mailing Address: ___________________  Fax No.: ________________________________
_________________________________  Telephone Nos.: __________________________
_________________________________  Email: ________________________________

‡ I have/have not * already obtained confirmation that they are willing to act in this capacity. (* Delete as appropriate)

________________________________________  __________________________
Signature of Head of Department          Date

FOR OFFICIAL USE ONLY
Approved by the Chair, Campus Committee for Graduate Studies & Research:

________________________________________
Signature

________________________________________
Date