



BOSTON UNIVERSITY SCHOOL OF MEDICINE
Division of Graduate Medical Sciences
715 Albany Street, Rm. L-315
Boston, MA 02118

THESIS TITLE APPROVAL PAGE
MASTER OF ARTS
(Please type or print)

NAME: _____ **Department:** _____

BU ID#: _____ **B .U. Phone#:** _____

Home Phone#: _____ **Email:** _____

Proposed Title Of Dissertation: _____

SIGNATURES APPROVED

First Reader: _____
(Print Name)

(Title) (Signature) (Date)

Second Reader: _____
(Print Name)

(Title) (Signature) (Date)

Third Reader: _____
(Optional) (Print Name)

(Title) (Signature) (Date)

RECEIVED BY DIVISION: _____

APPROVED BY: _____