



School of Graduate Studies
LSU Health Shreveport
Shreveport, Louisiana 71130

REQUEST FOR PRELIMINARY EXAMINATION

Type or Print Clearly

Student Name: _____
Last First Middle

Date of Exam: ____ / ____ / ____ Department: _____

Major Field: _____ Minor Field: _____

Anticipated Graduation Date: ☐ Summer ☐ Fall ☐ Winter _____
Year

RECOMMENDED DEFENSE / EXAMINATION COMMITTEE		
Type Name	Signature	Department
	Advisor	

APPROVALS:

Department Head Date: ____ / ____ / ____

Dean of the Graduate School Date: ____ / ____ / ____