Department of Applied Medicine and Rehabilitation
College of Health, and Human Services
Indiana State University
Terre Haute, Indiana

**APPROVAL OF RESEARCH PROJECT DEFENSE**

Name: _____ Student ID #: _____
Last First Middle

Title of Research Project: _____
_____

Date of Defense: _____

Approved by:

Committee Member:_____ Date:_____

Signature: _____

Committee Member:_____ Date:_____

Signature: _____

Committee Member:_____ Date:_____

Signature: _____

Committee Member:_____ Date:_____

Signature: _____

Committee Member:_____ Date:_____

Signature: _____

Committee Chair:_____ Date:_____

Signature: _____

Department Chair:_____ Date:_____

Signature: _____

Academic Dean:_____ Date:_____

Signature: _____

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Submit this form and a copy of the Research Project Proposal to the Research Project, Committee Chair, Program Director, Department Chair, and the Dean of the College of Health and Human Services
Distribution: Student, Committee Chairperson, Department Chairperson, Dean of the College of Health and Human Services

Revised 10/2011