

Notification of the commissioned Master´s Exam

Information about the student		
Study Code:	Matriculation number:	
Family name:	First name:	
Address:	ZIP Code:	Location:
E-Mail:	Phone number:	

Registration must take place at least 4 weeks before the examination date! Requirement is the Appropriation of the Master Thesis.

Date of the registration: _____

Signature of the student: _____

Commission Examination senate

Date of the exam:	Time of the Exam:
Audit Location (exact room name):	

Presidency (Supervisor)	
Name:	
Organizational unit/clinic Department:	
E-Mail:	Phone number:

Auditor 1	
Name: (Akad.Titel)	
Organizational unit/clinic Department:	
E-Mail:	Phone number:

Auditor 2	
Name: (Akad.Titel)	
Organizational unit/clinic Department:	
E-Mail:	Phone number:

I hereby declare my willingness to conduct the above-mentioned Commissioned Master's Examination:

Presidency

Auditor 1

Auditor 2