DEPARTMENT OF PHARMACOLOGY & TOXICOLOGY
University of Toronto

Ph.D. SCREENING COMMITTEE

Please return the completed form to the Graduate Office at least **FOUR WEEKS** prior to the date of the proposed screening.

To Be Filled Out by Student/Supervisor

NAME OF STUDENT: _____

CONFIRMED DATE & TIME OF SCREENING: _____

Ph.D. PROJECT/THESIS TITLE: _____

_____

SCREENING COMMITTEE (A total of 6 Committee Members (including 3 GEC) is required)

Provide **FULL CONTACT INFORMATION** including Email Address; Telephone and FAX Numbers for all **non-pharmacology faculty**. Attach separate sheet if necessary.

1. Supervisor(s):_____

2. Future Supervisory Committee Member_____

3. External Rep. _____Department_____
   (Must have **Primary Appointment** in another Department)
   (Cannot be a member of the Student's Supervisory Committee)

4. Other Voting Member _____
   (Optional - May be future Supervisory Committee Member)

To be filled out by Graduate Office

5. G.E.C. Member _____

6. G.E.C. Member _____

7. G.E.C. Member _____