Research Contract

Student Name_____

Title of Research _____

Primary Responsible Faculty Member _____

Mailing Address_____Telephone_____

Other Faculty Members Involved _____

_____

Institution Where Research Is Offered _____

Full Address _____

Telephone Number Where You Can Be Reached _____

Semester Research Is Offered_____Give Actual Dates _____

Number of Hours Per Week Participation By Student _____

Number of Formal Conference Hours Per Week Participation by Student _____

Number of Credit Hours Per Semester Student Qualifies For _____

Method or Criterion of Student Evaluation _____

_____

Method of Criterion of Course Evaluation_____

_____

***PLEASE LIST DETAILED OBJECTIVES OF THIS RESEARCH ON A SEPARATE SHEET.
RESEARCH CONTRACTS MUST BE TURNED INTO THE DEPARTMENT AT LEAST THREE WEEKS PRIOR TO THE ABOVE SPECIFIED STARTING DATE FOR ASSURANCE OF APPROVAL OF THIS RESEARCH.
ALL APPROVALS NOTED BELOW MUST BE RENDERED PRIOR TO STUDENT STARTING RESEARCH.
RESEARCH SUPERVISORS WILL BE SENT A FINAL COPY OF THE APPROVED RESEARCH CONTRACT.

_____

Signature of Research Supervisor Printed Name Date

_____

Signature of Advisor Printed Name Date

_____

Signature of Director of Clinical Training Printed Name Date

_____

Signature of Department Chair Printed Name Date