



UNIVERSITY of NORTH TEXAS  
HEALTH SCIENCE CENTER at Fort Worth  
★  
School of Public Health

**REQUEST FOR THE SPECIALIZED COURSE QUALIFYING EXAMINATION  
DOCTOR OF PUBLIC HEALTH PROGRAM**

Date: \_\_\_\_\_

I, \_\_\_\_\_, have completed all but dissertation hours  
(Print Name)

of the Doctor of Public Health Program and request permission to take the Specialized  
Qualifying Examination.

\_\_\_\_\_  
Student's Signature

Coursework verified by:

\_\_\_\_\_  
Office of Student and Academic Services

\_\_\_\_\_  
Major Professor's Name (Please print)

\_\_\_\_\_  
Major Professor's Signature

cc: Major Professor  
Department Chair  
Department File Copy  
Dr.P.H. Student