

## Submission Instructions

Please complete this form and submit at least **two** weeks prior to the desired oral defense date. Once form is completed, please submit via email to [CDS@ashford.edu](mailto:CDS@ashford.edu), fax to 888.331.0568, or e-sign.

## Student Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Student ID: \_\_\_\_\_

Program:  PhD Education  PhD Human Services  PhD Org. Development & Leadership  PsyD

Specialization: \_\_\_\_\_

Doctoral Research Project Working Title: \_\_\_\_\_

## Oral Defense Request

Preliminary  Final

Please schedule the oral defense for one of the following options:

Day: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Day: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Day: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Synchronous Communication Medium Needed (Zoom, Skype, etc.)

Other Needs: \_\_\_\_\_

The following people need to be in attendance:

Chair Name: \_\_\_\_\_ Email: \_\_\_\_\_

Attendee Name: \_\_\_\_\_ Email: \_\_\_\_\_

Attendee Name: \_\_\_\_\_ Email: \_\_\_\_\_

Attendee Name: \_\_\_\_\_ Email: \_\_\_\_\_

Attendee Name: \_\_\_\_\_ Email: \_\_\_\_\_

Attendee Name: \_\_\_\_\_ Email: \_\_\_\_\_

## Consent to Record

My signature below acknowledges that my Oral Defense facilitated by Zoom will be recorded, and I give Ashford University the right, but not the obligation, to record my participation and appearance on video and audio tape. I understand that this video/audio recording will be used for educational and/or instructional purposes only within Ashford University.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Ashford University may distribute my recorded Oral Defense to other students, faculty, and staff for instructional and learning purposes.

I do not want Ashford University to distribute my recorded Oral Defense to other students, faculty, and staff for instructional and learning purposes.