

DEPARTMENTAL APPROVAL FOR PSY 593 RESEARCH DEVELOPMENT

NAME _____ NMU-IN _____
EMAIL ADDRESS _____ PHONE _____
YEAR _____ SEMESTER _____

TITLE OF RESEARCH PROJECT:

DESCRIPTION OF ACTIVITY:

Signature of Student

Advisor _____

Signature of Academic Advisor

Thesis Advisor _____

Signature of Thesis Advisor

Signature of Department Head

Date

THIS FORM IS TO BE RETURNED TO THE DEPARTMENT OF PSYCHOLOGICAL SCIENCE.

03/2021