



HARVARD
School of Dental Medicine

MMSc Thesis Defense Form

We, the undersigned, have read and approved the thesis of
Dr. [Insert student full name]
submitted in partial fulfillment of requirements for the degree of a
Master of Medical Science at the Harvard School of Dental Medicine.

[Insert student name and current degrees]

[Insert thesis title]

Signature

[Insert Defense Committee member's name]

Signature

[Insert Defense Committee member's name]

[Insert date of thesis defense]