Academic Program Review
Program Information

Date _____Program name _____

Program type:
____ Undergraduate
____ Graduate

Degree type:
____ Bachelor's
____ Master's
____ Doctoral
____ Certificate (specify _____)

Department _____

School/College _____

Degree Plan of Study Required
Total minimum credit hours (CH) _____
Number of didactic CH _____ Practicum/Clinical/Lab CH _____
Dissertation/Thesis/Project CH _____

External Accreditation/approval required for program? Yes No
If yes, please provide brief information on agency of accreditation and review cycle years _____

Special certifications/license required for program or faculty? Yes No

If this is a collaborative interdepartmental or interagency program, please provide brief information_____

Are there additional admission requirements for the above noted program (e.g., auditions, portfolio)? No Yes (please explain: _____)

Program director name: _____
Program director contact email and phone: _____

Signatures
Program Director _____ Date _____
Department Chair _____ Date _____
Dean _____ Date _____

Signatures for Interdepartmental Program (if applicable)
Program Director _____ Date _____
Department Chair _____ Date _____
Dean _____ Date _____