APPLICATION FOR TRANSFER OF CANDIDATURE AND PERIOD OF STUDY FOR A DOCTORAL PROGRAMME

All sections of this form must be completed

<table>
<thead>
<tr>
<th>Name:</th>
<th>Student No:</th>
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<tbody>
<tr>
<td>Degree:</td>
<td>Stage:</td>
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</tbody>
</table>

1. Date of first registration: ____________________________

2. Current type of candidature:  
   (see below)  
   a ☐  
   b ☐

3. Proposed new type of candidature:  
   a ☐  
   b ☐

**Type of Candidature, Period of Study and Registration Requirements**

Please note that overseas students who are transferring from full-time to part time studies may face implications with their visa. You are advised to contact the Visa Team (visa@ncl.ac.uk) for further guidance on this.

An applicant may be approved by the relevant postgraduate sub-dean as a conditional or unconditional candidate for the degree of Doctor of Philosophy in any of the following categories:

(a) as a candidate whose minimum period of advanced study and research in the University shall normally be not less than three years of full-time study;

(b) as a candidate whose minimum period of advanced study and research shall be not less than six years of part-time study.

4. The following documents are attached (please tick as appropriate):
   
   Letter from candidate: ☐  
   Other (please specify): ☐  
   Letter from supervisor: ☐
5. Summary of reasons for request:

Signed ________________ Date ____________  
(Candidate)  
Email Address for correspondence: ________________________________

Signed ________________ Date ____________  
(Main Supervisor)  
Name ________________________________

* Additional Signature  
Signed ________________ Date ____________  
Designation ________________________________  
Name ________________________________

Signed ________________ Date ____________  
(Head of School)  
Name ________________________________

STUDENTS IN THE FACULTIES OF HASS AND SAGE SHOULD RETURN THIS FORM TO THE  
RESEARCH STUDENT SUPPORT TEAM, LEVEL 2, KING’S GATE.  
STUDENTS IN MEDICAL SCIENCES SHOULD RETURN THIS FORM TO THE MEDICAL SCIENCES  
GRADUATE SCHOOL, CATHERINE COOKSON BUILDING

Dean of Postgraduate Studies’ comments:

Approved / Not approved (please delete as appropriate)  
Signed ___________________________ (Dean of Postgraduate Studies)  
Name: __________________________________  
Date: __________________________________

For Graduate School Office Use Only:  
System Input □  
DB Input □  
Signed ___________________________

* Where your Departmental/Faculty procedures require additional approval, for example, from the  
Director of Postgraduate Studies or second supervisor, this box should be completed.