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| College of Nursing and Health ProfessionsFaculty Re-Assigned Time Request |
| Number of re-assigned time credits requested. Not to exceed 3 credit hours in the academic year.\_\_\_\_ Fall Semester\_\_\_\_Spring Semester\_\_\_\_Summer Semester  | Faculty MemberDepartment and Chair |
| Brief description of the nature of the work that is beyond the usual expectation of the faculty member’s appointment.  |
| Brief description of how the work benefits the department and/or program. |
| Timeline for Completion of Tasks and Submission of Report |
| By signing below, I agree to complete the work outlined in this proposal and to submit a summary of the work completed following the timeline indicated above. I understand that not completing and/or not reporting the work may result in denial of future request for re-assigned time. |
| Faculty Member’s Signature:  | Date: |
| By signing below, I approve this request and verify that the work will benefit the department and/or graduate program. |
| Program Chair Signature: | Date: |
| By signing below, I approve this request. |
| Assistant Dean’s Signature: | Date: |