Stephen F. Austin State University

Workload Reassignment

Request Form

Faculty Name: SSN:

Department: **Semester:**

Teaching Load Reassignment Request: ***credit hours***

Proposed Compensation for Reassignment:

External Funding Source(s) and Amount:

Expected Outcomes for Reassignment Service (list below):

Outline Time Commitment (in approximate hours):

Current Status of Project/Activity, if applicable:
(provide documentation as an attachment)

To be completed by department chair/director: If this request is granted, can the department meet its student instructional needs without additional resources? ☐ Yes ☐ No

In signing, the faculty member acknowledges that (1) the information provided is accurate; (2) the failure to accomplish reassignment objectives could negatively impact one's annual evaluation and merit pay; and (3) an outcome assessment form will be completed prior to the deadline if reassignment is awarded.

Faculty Signature: ________________________________ Date:

Approved/Not Approved ___________________________ Date:
Department Chair/Director

Approved/Not Approved ___________________________Date:
Dean

Approved/Not Approved ___________________________Date:
Provost

Stephen F. Austin State University

Reassignment Outcome Assessment Form

To be completed by the last day of the semester for which reassignment was approved. Follow up reports may be required.

Validate the extent to which reassignment outcomes have been fulfilled. Appropriate documentation should be attached or may be requested.

Please justify any failures to fulfill the expected outcome(s):

Please summarize the benefits that accrued to the department, college, and/or university as a result of the reassignment service:

Faculty Signature: ____________________________________ Date:

Please forward a copy of the completed form to the department chair/director, Dean, and Provost.