Stephen F. Austin State University
Workload Reassignment
Request Form

Please open the form in Adobe Reader to avoid problems saving.

Faculty Name: **CID**:

Academic Unit: **Semester:**   **Academic Year:**

    Program Coordinator   Curriculum Development   Research   Service   Grant

    Other

Teaching Load Reassignment Request:

To be completed by academic unit head: If this request is granted, can the academic unit meet its student instructional needs without additional resources?   **Yes**   **No**

Expected Outcomes for Reassignment Service (list below):

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

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 eligibility for merit pay; and (3) an outcome assessment form will be completed prior to the deadline if reassignment is approved.

Faculty Signature: _____ Date:

Approved/Not Approved _____ Date:
                        Academic Unit Head

Approved/Not Approved _____Date:
                        Dean