Stephen F. Austin State University

Workload Reassignment
Request Form

Faculty Name: **CID**:

Academic Unit: Please Select: **Semester:** Please Select: **Academic Year:** Select:

◯ **Program Coordinator** ◯ **Curriculum Development** ◯ **Research** ◯ **Service** ◯ **Grant**

◯ **Other**

Teaching Load Reassignment Request: Please Select:

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