University of South Aiabama

Faculty Name:
Department:

Amount of Reassignment Instructional Time Requested

No. Credit/Contact Hrs.
Time Period of Reassignment

D escription/Justifi cati on of Reassi gnment

Description of Outcome of Reassigned Time

*****{<** * ***** * ***** ***

REQIIESTED
Faculty Member

RECOMMENDED
Department Chair

APPROVED
Academic Dean

Request for Faculty Reassignment Instructional Time

Date

Date

Date

INFORMATION
Senior Vice President for Academic Affairs Date