



Office of Academic Affairs
1650 Bedford Avenue, Room, B-3010
Phone: 718-270-5010

FACULTY REASSIGNED TIME REQUEST FORM

INSTRUCTIONS:

To be completed by the faculty member who is requesting Reassigned Time. After completing and signing the form, submit it to Department Chairperson.

Semester: _____

Year: _____

Faculty Name: _____ **Department:** _____

Tenure Status: ☐ Tenured ☐ Non-Tenured **Total Contact Hours Requested:** _____

Type of Reassigned Time Requested:

☐ **Chairperson: Hours requested:** _____ ☐ **Deputy Chairperson: Hours requested:** _____

☐ **Scholarly Activities** (PSC CUNY contractual for untenured faculty) **Hours requested:** _____

☐ **Grant Related Activities: Total hours requested:** _____

Funding source: _____ Grant Name/Grant number: _____

PI: _____

Funding source: _____ Grant Name/Grant number: _____

PI: _____

☐ **Other: Total hours requested:** _____

Specify _____ Funding Source _____

Specify _____ Funding Source _____

Faculty Member: *I agree to submit my activities for this reassigned time to Department Chairperson at the end of the semester.*

Faculty Signature: _____ **Date:** _____

FACULTY REASSIGNED TIME APPROVALS:

Department Chairperson

☐ **Recommended** - I support the activities of all listed hours. The requested hours are within the faculty's workload. I recommend approval.

☐ **Recommended with reduced** - I support the activities with reduced hours to hours.

☐ **Not Recommended** Reason: _____

Chairperson/Designee Name: _____

Signature: _____

Date: _____

FACULTY REASSIGNED TIME APPROVALS:

Office of the Dean

☐ **Recommended** - I support the activities of all listed hours.

☐ **Not Recommended** Reason: _____

Dean/Designee Name: _____

Signature: _____

Date: _____

FACULTY REASSIGNED TIME APPROVALS:

Office of the Provost

☐ **APPROVED**

☐ **DENIED**

Reason: _____

Provost/Designee Name: _____

Signature: _____

Date: _____