CUNY The City University of New York **Medgar Evers College of The City University of New York**

Office of Academic Affairs

Faculty Reassigned Time Request Form

Instructions

To be completed by the faculty member requesting Reassigned Time. After completing the form, please submit the Form to your Department Chairperson and School Dean for his/her recommendation, signature and date. Lastly the form is sent to the Provost for his/her recommendation and signature and then forwarded to the budget office for processing.

Date _____

Faculty Name _____ **Department(s)** _____

Semester(s) for which Reassigned Time is being requested. _____

How many hours of Reassigned Time are you requesting? _____

Please state below, the reason(s) for the Reassigned Time.

_____

_____

_____

Please indicate the source(s) of funding for the requested Reassigned Time. Please attach supporting documentation (RF grant number, Department Name/Code(s), University approval).

_____

_____

_____

Required Recommendations and Signatures

Recommended ☐ **Not Recommended** ☐ _____ **Date** _____

Department Chairperson's Signature

Recommended ☐ **Not Recommended** ☐ _____ **Date** _____

School Dean's Signature

For Official Use Only

Reassigned Time **Approved** ☐ **Denied** ☐ **Semester(s)** _____

Date of Decision _____ **Provost's Signature** _____

1650 Bedford Avenue • Brooklyn, New York 11225 • 718.270.5010 • 718.270.5177 fax