



WORKLOAD RELIEF REQUEST

Date: _____

Department: _____

Name: _____

Rank: _____

Employee ID: _____

Campus Address: _____

For the period: Fall Term: Sept 1, _____ to Feb 1, _____

Spring Term: Feb. 1, _____ to July 1, _____

The workload relief requested is (check one):

one semester of full relief

two semesters of half relief

In conjunction with the birth/adoption of

Name (if known): _____

Expected Date of birth: _____

Supporting Material:

- A. The recommendation must be accompanied by a memorandum from the faculty member requesting the workload relief and asserting that he/she is the primary caregiver of a newborn child or newly-adopted infant less than one year of age.
- B. On a separate sheet, please provide the plan of how the Department will facilitate the workload relief, including any requests for teaching budget support from the Office of the Dean of the Faculty.

Signatures:

Chair of Department/Chair of Second Department (if joint)

Date

Action by the Office of the Dean of the Faculty

Date

Please note that this form will be returned to the department if it does not include all pertinent information, including the attachments.