

MEDICAL FACULTY
PDH/DH RECOMMENDATION for ONGOING and TERM APPOINTMENTS
COLLEGE OF MEDICINE, UNIVERSITY OF SASKATCHEWAN

DEPARTMENT: _____

1. FULL NAME of Recommended Appointee:

Surname: _____

First name: _____

Middle name: _____

Date of birth (DD/MM/YEAR): _____

2. LOCAL MAILING ADDRESS: _____

3. EMAIL (SHA email & email provided): _____

4. PHONE NUMBER: _____

5. Recommendation TYPE:

New ongoing appointment to faculty

Existing appointment expiring; renew to ongoing faculty appointment

Term appointment (eg. Locum, Visiting professor) End Date: _____

6. CPSS License # _____

7. License type: Regular _____ Provisional _____ Other (ex: Ministerial) _____

6. Academic Credentials _____

7. Effective Appointment Date (within 6 months of present date): _____

I have discussed this recommendation with the appointee, who is aware of the duties and responsibilities involved with being named to university/department faculty.

Date

Signature of Department Head

Encl: Appointee's current C.V.

Email all documents to: medicine.facultyengagement@usask.ca

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For Use by College of Medicine

Approved by: _____
Signature of Dean (or Vice Dean Faculty Engagement)

Date