SUPPORT FACULTY

PDH/DH RECOMMENDATION for APPOINTMENT and RENEWAL

COLLEGE OF MEDICINE, UNIVERSITY OF SASKATCHEWAN

DEPARTMENT: _____

1. FULL NAME of Recommended Appointee:

   Surname:_____

   First name: _____

   Middle name: _____

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

2. LOCAL MAILING ADDRESS:_____

   _____

3. EMAIL: _____

4. PHONE NUMBER: _____

5. Recommendation TYPE:

   ____ New appointment to CoM support faculty

   ____ Renewal: Existing appointment expiring/expired

6. Professional License # (if applicable)_____Discipline _____

7. Academic Credentials_____(*If no PhD, please provide additional information justifying appointment/renewal)*

8. 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 College of Medicine support 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