PERELMAN SCHOOL OF MEDICINE – Reduction in Duties Request Form

Faculty Name: ________________________________________________________________

Department: __________________________________________________________________

Current track: ____________________ Current rank: ____________________________

_____% Reduction in Duties requested.

Start date: __________

End date: __________ *

Purpose: (Faculty Handbook Policy II.E.2.

________________________________________________________________________________________

________________________________________________________________________________________

*As stated in the Faculty Handbook Policy II.E.2., I understand that a reduction in duties may not exceed a total period of six years. In addition, a reduction in duties is always accompanied by a proportional reduction in salary and in those benefits, such as life insurance and retirement contributions, that are salary-based.

___________________________          ______________________________
Faculty Name, Degree          Date

Approved by:

___________________________          ______________________________
Department Chair Signature      Date

___________________________          ______________________________
Dean’s Signature          Date

* A reduction in duties is granted only for whole years and must be approved by the Provost’s Staff Conference. Reduction requests must be resubmitted annually for duration of Reduction.