UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY
Faculty Recommendation Form

Candidate's Name:	
Department:	Division:
	Date of Birth:
Employee ID Number:	Citizenship:

Proposed Action (check all that apply):

Appointment ☐ Change in Appointment ☐

Reappointment ☐ Additional Appointment ☐

Promotion ☐ Grant Tenure ☐

PRIMARY APPOINTMENT

Current Title:	
Proposed Title:	
Effective Date:	End Date:

Specify Activity Components for Professor, Associate Professor, and Assistant Professor (reappointment):

Clinical	Research	Scholarship	Institutional Scholarship	Teaching
☐	☐	☐	☐	☑

only one of these may be selected

JOINT APPOINTMENT(S) (for more than one joint appointment, attach second sheet)

Current Title:	
Proposed Title:	
Effective Date:	End Date:

Remarks