



FACULTY AFFILIATE RECOMMENDATION FORM

INDIVIDUAL COMPLETES

Name: Dr. Mr. Ms. _____
First Name Middle Name or Initial Last Name

Social Security Number _____ Date of Birth _____ UM ID Number _____

Current Address _____
Street City State Zip

E-mail Address _____ Phone _____

Academic Department _____

Appointment is from October 1 (or date of appointment) through September 30, annually.

New Faculty Affiliate Renewal

Are you a faculty affiliate or faculty associate in another department/program? _____

If yes, which department/program? _____

Current employer: _____

DEPARTMENT COMPLETES

Qualifications for Appointment

Highest Degree Received _____ Date Received _____

Institution _____

Professional Experience _____

Expected Academic Contributions to the University

Attach appropriate qualification documentation.

- CLASSIFICATION**
- A** – Sufficient research or clinical collaboration requiring University resources such as remote electronic library access.
 - B** – Limited, specific interaction not requiring general access to University resources.

Chair (if applicable)

Date

Dean

Date

Provost and Vice President for Academic Affairs