**Request for Reappointment for Adjunct/Clinical Faculty at the Geisel School of Medicine at Dartmouth**

Note: All items must be completed by the applicant and reviewed by the Department Chair/Institute Director before submitting this form to the Office of Faculty Affairs.

See Faculty Appointments, Promotions, and Titles document at the [Geisel Faculty Handbook](http://geiselmed.dartmouth.edu/faculty/fac_info/) for criteria related to appointment as adjunct or clinically-prefixed members of the Geisel Faculty.

*Appointments as Adjunct Faculty, Instructors and Lecturers are for one academic year ending on June 30, or for the term of the course with which the faculty member is associated. Clinical appointments are for two academic years ending on June 30. Appointments must be actively renewed for faculty status to continue. All rights and privileges associated with membership in the Geisel faculty terminate at the time of appointment termination.*

Name of faculty member: Date:

Department: Chair/Director:

Current Profession: Professional degree:

-Most recent faculty title at Geisel or other academic institution:

Dates Institution Title

Chair has proposed the appointment as: (e.g., Clinical Assistant Professor)

**Provide requested information below. If not applicable, put n/a.**

**□** I make a formal contribution (evaluation and/or grading) to a required undergraduate medical education course or clerkship.

List course/program:

□ I make a formal contribution (evaluation) to formal residency or fellowship education.

List program:

□ I have a recognized contribution to non-required courses (e.g., I am a listed as an instructor/lecturer)

Dates Course Taught Contact hours/year (specify which) Number of students (if applicable)

□ I have a documented role as key personnel on awarded or submitted sponsored research programs at Geisel:

Dates of award Sponsoring organization Role Principal Investigator (@Dartmouth/DH/VA)

Other pertinent information/roles:

**Current Contact Information:**

Mailing Address: ­­­
 Street City State Zip

Preferred Email Address:

Signature: Date: