Clinical Faculty Promotion Review Form

Name: _____ _____ _____ _____
first *middle* *last* *suffix (Jr., II, etc.)*

Highest Degree Obtained: _____ **Employee Number** _____

Experience (years) _____ at Ohio University _____ as Clinical Prof. at OU
_____ at other higher ed. institution _____ other employment

Current Rank ☐ Assistant Clinical Prof. ☐ Associate Clinical Prof. **Date Current Rank Awarded** _____
month/year

Date Current OU Employment Commenced _____
month/year

Office Address: _____ **OU Email Address:** _____
building and room number

The person named above is herewith reviewed for

Promotion to the Rank of ☐ Associate Clinical Prof. ☐ Clinical Prof.

Department, School, or Regional Higher Ed. Division _____
Please do not use abbreviations.

College or Regional Campus Name _____
Please do not use abbreviations.

Campus: _____

Promotion Effective Date: _____
First day of work in the upcoming academic year.

PROMOTION RECOMMENDATION - sign as applicable

Name *(please print/type)*	**Signature**	**Recommendation**	**Date**
Departmental Promotion Committee Chair		☐ Yes ☐ No	Date
Chair/Director/Prog. Coordinator		☐ Yes ☐ No	Date
College Promotion Committee Chair		☐ Yes ☐ No	Date
College or Regional Campus Dean		☐ Yes ☐ No	Date
Elizabeth Sayrs Executive VP and Provost		☐ Yes ☐ No	Date
Hugh Sherman President		☐ Yes ☐ No	Date

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