

**University Of Connecticut**  
**Office of the Provost**  
**Sabbatical Leave Request Form**

1. NAME OF FACULTY MEMBER  
(Include Employee Number)

2. RANK:

3. DEPARTMENT/SCHOOL:

4. DATE OF LAST SABBATICAL:

5. DATES OF SABBATICAL REQUESTED:

Full Year at Half Pay

Six (6) Months at Full Pay

6. ACTIVITIES TO BE UNDERTAKEN DURING THE SABBATICAL AND YOUR PLAN FOR HOW YOUR RESPONSIBILITIES WILL BE COVERED IN YOUR ABSENCE. Please attach explanation on a separate sheet. If you are grant funded, please also submit approval from your granting agency.

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7. FACULTY AGREEMENT

I agree to return amounts paid to me during the sabbatical leave if I do not return to active service of UConn Health for a period of one year following the expiration of the sabbatical leave.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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8. DEPARTMENT HEAD APPROVAL

Departments are expected to make every effort to cover the assignments of the faculty member with departmental resources. \$ \_\_\_\_\_ is needed to cover the responsibilities of the faculty member. Attach a justification for this request on a separate sheet.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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9. DEAN'S APPROVAL

Resources Committed to Sabbatical Leave: \$ \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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10. PROVOST'S APPROVAL

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

Provost's Office will submit completed form to the Dean's Office of the School of Medicine or School of Dental Medicine. Following approval of the UConn Health Board of Directors, Human Resources in Farmington will be notified.

Board of Directors Approval Date: \_\_\_\_\_