

**St. Cloud State University  
School of Graduate Studies**

**RECOMMENDATION FOR APPOINTMENT TO THE GRADUATE FACULTY**

Name

First

Middle

Last

Department

Academic preparation:

Degree

College or University

No. semester hours beyond highest degree

Teaching experience:

- College/University            years  
 Other                                years

Based on these qualifications and in accordance with the policies of the School of Graduate Studies, the applicant is recommended for membership on the Graduate Faculty.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Department Chair Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
College Dean Signature

This appointment:

- is  
 is not approved.

\_\_\_\_\_  
Graduate Dean Signature

\_\_\_\_\_  
Date