

# Department Evaluation Guidelines Revision Form

(to be completed by Department Chair)

Date:

Name:

Department:

Have these changes been approved by a majority of full-time faculty in the Department? Yes No

Votes: Yes\_\_\_\_ No\_\_\_\_

Please list the proposed changes

Page number(s)	Revision	Rationale for revision

Department Chair Signature:

Comments:

Dean Signature:

Comments:

Provost Signature:

Comments: