**Faculty of Health Studies**

**Request for Sessional /Overload Contract:**

Name:  Previous Name: (if applicable): 

Department:  Rank:  Change of address: 

Address: Box/Street #  City:  P.C. 

E-Mail:  Phone No. 

Payment Requested (Bi-Weekly, End of Contract, Specific Date): 

 

**Type of Appointment (check all that apply):**

  



If Shared or Team-Taught: Name of Instructor and Percentage: 

If Practica or Tutorial Name (s) of Students: 

Course Number:  Section (Z01/A01/W01/T01): 

Course Title: 

Date of First Class/Clinical:  Date of Last Class/Clinical: 

Credit hours of Course:  Credit hours of Contract: 

Contact Hours Req’d per Week (Theory/Lab/Clinical):  # of Weeks: 

Location (Bdn/Wpg/Off-Campus):  Anticipated Enrolment: 

Other Conditions: 

Signature:  Date: 

***For Office Use Only:***

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*Attached (New Sessionals):*

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