Designation of Laboratories and Studios During Pandemic Event Approval Form

Date: ______________

Requestor: Name ____

Title ____

Department ____

College/School ____

Contact Information ____

Location of Laboratory or Studio: ____

Dates Facility will be used: ____

Names of Essential Personnel in the Facility (Note: Only faculty and staff who are approved as Essential for on-campus work can be in the laboratory.)

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Day **Night** **Weekends**

Approximate number of hours per week will the facility be operational: _______

Requesting Designation of: Essential Partially Essential

Nature of the Research being Conducted:

Justification for Requesting Designation (Please be very specific):

Approvals:

Dean:

______________________________ ______________________________ Approved Denied

(Typed Name) (Signature) (Circle one)

Senior Associate Dean College of Medicine: (for CoM only)

______________________________ ______________________________ Approved Denied

(Typed Name) (Signature) (Circle one)

Vice President for Research and Economic Development:

______________________________ ______________________________ Approved Denied

(Typed Name) (Signature) (Circle one)