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)