**WORKING WELL PLAN**

**Resumption of Staff Operations**

**School of Medicine**

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| --- | --- |
| **Department Name: Date Completed:**  **Name of Leader Completing this Form:** | |
| **Employees** | **Total # of Employees in Department:**  **# Employees Currently Onsite: % Currently Onsite:**  **# Employees Requested to Return to Onsite: % Requested to Return:**  **Proposed Return Date:**  **Please list or attach, either by employee name or classification groups, the employees requested to return:** |
| **Justification for Return** | **All employees who can work remotely are expected to do so until the County has rescinded stay at home orders or UC Irvine has announced otherwise. Please provide a statement to support why the employees requested to return to work are unable to continue working from home without disruption to operations:** |
| **Physical Space** | **Prior to returning any employees to onsite work, EH&S must evaluate the physical space to ensure physical distancing guidelines can be met. Additionally, departments must complete the COVID-19 Protection and Monitoring Plan as required by the State of California and attach to this Working Wellness Plan.**  **Appropriate Sanitizers Available: Y / N**  **Appropriate Signage Installed: Y / N**  **COVID-19 Protection and Monitoring Plan Attached: Y / N**  **Approval by EH&S:** |
| **Resumption of Work Training** | **Prior to returning to onsite work, Employees must view EH&S’ COVID-19 Training. Please confirm all employees have completed the training:**  **Return to Work Training Completed by all Employees: Y / N** |
| **Managing Team and Communication** | **Communications Meetings Planned / Conducted:**  **All Staff: Y / N**  **Team: Y / N**  **One-on-One: Y / N** |

**DEPARTMENT LEADER APPROVAL:**

Signature Date

**HR BUSINESS PARTNER REVIEW:**

Signature Date

**ASSISTANT DEAN APPROVAL:**

Signature Date

**DEAN, SCHOOL OF MEDICINE APPROVAL:**

Signature Date