

INFANT AT WORK PROGRAM INDIVIDUAL PLAN

☐ New Plan ☐ Revised

Part 1 – General Information

Employee Name (Parent/Legal Guardian):				Personnel ID #:			
Division and Office:				Supervisor Name:			
Work Phone:		Cell Phone:		Building:		Cube/Office #:	
Personal Email Address:							
Baby's Name:			Baby's Date of Birth: / /		Baby's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Date Baby Begins Program*: / /				Date Baby Ends Program*: / /			
Please indicate the days and times the baby will be present in the workplace:							
Week 1:							
<input type="checkbox"/> Mon.	Start:	<input type="checkbox"/> Tues.	Start:	<input type="checkbox"/> Wed.	Start:	<input type="checkbox"/> Thurs.	Start:
	End:		End:		End:		End:
Week 2 (only needs to be completed if working a 9/80 schedule):							
<input type="checkbox"/> Mon.	Start:	<input type="checkbox"/> Tues.	Start:	<input type="checkbox"/> Wed.	Start:	<input type="checkbox"/> Thurs.	Start:
	End:		End:		End:		End:
*Baby must be at least 6 weeks of age at the start of the Infant at Work Program and 6 months or younger at the end of the program.							

Part 2 – Care Providers

The following persons have agreed to be Care Providers, responsible for providing care for my baby in the workplace, when I become temporarily unavailable to provide care. Provider care is not to exceed 1 hour within a 4 hour period. Approved Care Provider Agreements must be submitted with this Individual Plan.

Primary Care Provider Name:		Division and Office:	
Work Phone:		Cell Phone:	
Secondary Care Provider Name:		Division and Office:	
Work Phone:		Cell Phone:	

Part 3 – Specific Information

Include any specific plan information or requirements in the space below (optional):

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Part 4 – Emergency Contacts

Contact Name:	Relationship:
Primary Phone:	Secondary Phone:
Contact Name:	Relationship:
Primary Phone:	Secondary Phone:

Part 5 – Agreement

By signing this agreement, I hereby certify that I have read the Infant at Work Program Policy and Procedure (07.063). I understand and agree to comply with the terms and conditions set forth in the Policy and Procedure. I further understand

and agree that, in the event I fail to comply with such terms and conditions, or otherwise fail to meet any Program criteria, whether or not such criteria are set forth herein this Policy and Procedure, my Program eligibility may be terminated, requiring me to remove my baby from the workplace.

I acknowledge the Washington State Department of Health is offering participation in the Infant at Work Program as a courtesy to Department employees who are new mothers, fathers, or legal guardians. Accordingly, I further acknowledge the Department reserves the right to terminate an employee's eligibility, with or without cause, or to cancel or retire the Program in part or in its entirety, with or without cause, requiring me to remove my baby from the workplace immediately.

I have discussed this plan with my supervisor. I understand that I can bring my baby to the workplace upon final approval of this plan by the Office of Human Resources. If my plan changes, I agree to complete a revised plan for discussion and approval.

Employee Signature:		Date:	
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Part 6 – Approval

Supervisor Signature:		Date		<input type="checkbox"/> Approved <input type="checkbox"/> Denied*
Office Director Signature:		Date		<input type="checkbox"/> Approved <input type="checkbox"/> Denied*
Appointing Authority Signature:		Date		<input type="checkbox"/> Approved <input type="checkbox"/> Denied*

*Reason for Denial: _____

Part 7 – HR Review

This request complies with the Infant at Work Program Policy and Procedure:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Approved/Signed Care Provider Agreements and Waiver of Liability forms received:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Risk Management and Facilities notified:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Human Resource Signature:		Date:	
Comments: _____ _____			