![Department of Corrections - Washington State]

INFANTS AT WORK
INDIVIDUAL CARE PLAN APPLICATION

☐ New   ☐ Revised   Date: _____

GENERAL INFORMATION

Parent/legal guardian name: _____   Personnel ID number: _____
Work phone: _____   Cell phone: _____   Email address: _____
Division/facility/office: _____   Manager/supervisor name: _____
Building address: _____

Infant's name: _____   Date of birth: _____   ☐ Male ☐ Female
Estimated program begin date: _____   Estimated program end date: _____

Infant must be at least 6 weeks of age and no more than 6 months of age to participate in the Infants at Work Program

Indicate the days and times the infant will be present in the workplace.

Week 1				
☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday
Start: _____	Start: _____	Start: _____	Start: _____	Start: _____
End: _____	End: _____	End: _____	End: _____	End: _____

Week 2 (only needs completed if working a 9/80 schedule)				
☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday
Start: _____	Start: _____	Start: _____	Start: _____	Start: _____
End: _____	End: _____	End: _____	End: _____	End: _____

ALTERNATE CARE PROVIDERS (ACP)

The following persons have agreed to be ACPs, responsible for providing care for my infant in the workplace when I become temporarily unavailable to provide care. ACPs may provide care up to one hour in a 4 hour period. Approved Alternate Care Provider Agreements must be submitted through the ACP's chain of command to the Appointing Authority.

_____   _____   _____   _____
First ACP name   Division/facility/office   Work phone   Cell phone

_____   _____   _____   _____
Second ACP name   Division/facility/office   Work phone   Cell phone

EMERGENCY PLAN AND SPECIFIC INFORMATION

Include any emergency plan (required) information or specific plan (if applicable) information/requirements below.

_____

EMERGENCY CONTACTS

_____   _____   _____   _____
Contact name   Relationship   Work phone   Secondary phone

_____   _____   _____   _____
Contact name   Relationship   Work phone   Secondary phone

AGREEMENT

I acknowledge the Department is offering participation in the Infants at Work Program as a courtesy to employees who are new mothers, fathers, or legal guardians. By signing this agreement, I certify that I have read DOC 800.130 Infants at Work Program and agree to comply with the terms and conditions.

In the event I fail to comply with the terms and conditions, or otherwise fail to meet any program criteria, my eligibility may be terminated in part or entirely, and I will be required to remove my infant from the workplace immediately.

I have discussed this plan with my manager/supervisor and understand I can bring my infant to the workplace only upon final approval of the Appointing Authority. I agree to complete a revised plan for discussion and approval if my plan changes.

I acknowledge that I have read, understand, and agree to the terms of the Individual Care Provider Agreement.

Parent name	Signature	Date

DECISION

☐ Approved ☐ Denied

Manager/supervisor	Signature	Date

☐ Approved ☐ Denied

Appointing Authority	Signature	Date

Reason for denial:

Comments:

HUMAN RESOURCES REVIEW

This request complies with the Infants at Work Program procedures. ☐ Yes ☐ No

Alternate Care Provider Agreement(s), Workspace Checklist, and Liability Waiver forms received. ☐ Yes ☐ No

Name	Signature	Date

Comments:

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14. Upon completion, the data classification category may change.

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