**PARENT AGREEMENT - Infants at Work**

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| ***Related Policy:*** [HR.01.35 Infants at Work](http://sp.des.wa.gov/des/Documents/InfantsintheWorkplacePolicy.pdf) |
| ***About this form:*** This form is used by an employee when requesting to participate in the Infants at Work program.* *Parent: Complete this form and submit, along with the* [*Waiver of Liability*](http://sp.des.wa.gov/des/Documents/WaiverofLiability.docx) *form to your supervisor.*
* *Supervisor: Review and approve or deny program participation. If you approve the parent to participate in the program, submit to your appointing authority with the parent’s application package.*
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| **GENERAL INFORMATION** |
| Last Name: | First Name, Middle Initial: | Personnel ID Number: | Work Phone:  |
| Location (Building/Cubicle or Office): | Division (Organization Unit): | Supervisor’s Name: |
| Infant’s Name: | Infant’s Date of Birth: | Plan Type[ ]  Initial [ ]  \*Revised \* If revised, effective date  |
| Date Baby Begins Program\*:  | Date Baby Ends Program\*:  |
| **TIMES INFANT WILL BE IN THE WORKPLACE** |
| **Week 1** |
| [ ]  **Mon.** | Start: | [ ]  **Tues.** | Start: | [ ]  **Wed.** | Start: | [ ]  **Thurs.** | Start: | [ ]  **Fri.** | Start: |
| End:  | End:  | End:  | End:  | End:  |
| **Week 2 (only complete if working a 9/80 schedule)** |
| [ ]  **Mon.** | Start: | [ ]  **Tues.** | Start: | [ ]  **Wed.** | Start: | [ ]  **Thurs.** | Start: | [ ]  **Fri.** | Start: |
| End:  | End:  | End:  | End:  | End:  |
| **CARE PROVIDER INFORMATION** |
| Primary Care Provider Name: | Division/Office: | Work Phone: | Location (Building/Cubicle or Office): |
| Secondary Care Provider Name: | Division/Office: | Work Phone: | Location (Building/Cubicle or Office): |
| **EMERGENCY PLAN AND OTHER RELEVANT INFORMATION** |
| Include any other relevant plan information or requirements here (be specific): |
| By signing this agreement, I hereby certify that I have read the Infants in the Workplace Program Policy. I understand and agree to comply with the requirements of the Policy. Additionally, I acknowledge that the agency reserves the right to terminate my eligibility, with or without cause, or to cancel or retire the Infants in the Workplace Program in part or in its entirety, with or without cause, requiring me to remove my infant from the workplace.I have reviewed this agreement with my supervisor. I understand that I can bring my infant to the workplace upon final approval to participate in the program by Human Resources. If circumstances require a change to this agreement, I agree to complete a revised agreement for discussion and approval.  |
| Parent Signature: | Date |

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| **EMERGENCY CONTACTS** |
| Contact Name: | Relationship: | Primary Phone: | Secondary Phone: |
| Contact Name: | Relationship: | Primary Phone: | Secondary Phone: |
| **APPROVAL** |
| Supervisor Signature: | Date:  | [ ]  Approved[ ]  Denied\* |
| Appointing Authority Signature: | Date:  | [ ]  Approved[ ]  Denied\* |
| \*Reason for Denial: [ ]  Safety Concern [ ]  Performance Issue [ ]  Other: |
| **HR REVIEW** |
| Human Resource Designee Signature: | Date:  | [ ] Approved[ ] Denied\* |
| \*Reason for Denial: [ ]  Safety Concern [ ]  Performance Issue [ ]  Other: |
| **ATTACHMENTS AND NOTIFICATIONS** |
| [ ]  Care Provider Agreements [ ]  Waiver of Liability[ ]  Work Space Inspection Checklist [ ]  Building manager notified |