New Plan _____ Revised Plan_____

Department of Health and Human Services

INDIVIDUAL WORK PLAN

Infant-at-Work Program

I. GENERAL INFORMATION

Name of Parent/Employee: _____ Home Phone: _____-_____-_____

Name of Other Parent: _____ Phone: _____-_____-_____

Name of Infant: _____ *Estimated Date of Birth: _____/_____/_____

Estimated Program Start Date: ____/_____/_____ Estimated Program End Date: ____/_____/_____

Indicate days and times baby will be present in the workplace:

Mon. _____ Tues. _____ Wed. _____ Thurs. _____ Fri. _____

Sat. _____ Sun. _____

II. SPECIFIC INFORMATION

Include any specific plan information or requirements in the space below to include the following:

- Where will the baby be located? _____
- What is the day care backup plan? _____
- What equipment/furniture will you have in the workplace? _____
- What arrangements have been made for changing and disposal of diapers? _____

  _____
- What arrangements are in place for workplace meetings for which the baby cannot attend? _____

  _____

*Employee must provide actual date of birth to the H.R. Representative after delivery: _____
Actual Date of Birth

III. IN CASE OF EMERGENCY CONTACT

- Name of person to contact in an emergency: _____

  Relationship: _____

  Address: _____

  _____

  _____

  Work phone: _____/_____/_____(ext.)_____

  Home phone: _____/_____/_____

- Name of person to contact in an emergency: _____

  Relationship: _____

  Address: _____

  _____

  _____

  Work phone: _____/_____/_____(ext.)_____

  Home phone: _____/_____/_____

IV. AGREEMENT

By signing this *Agreement* hereunder, I hereby certify that I have read the Infant-at-Work policy. I understand and agree to comply with the terms and conditions set forth in the Infant-at-Work policy. 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 these guidelines, my program eligibility may be terminated, requiring me to remove my infant from the workplace.

I acknowledge the Division of _____ is offering participation in the Infant-at-Work program as a courtesy to Division of _____ employees who are new mothers and fathers, and not as an employee benefit. Accordingly, I further acknowledge the Division of _____ _____ reserves the right to terminate a participant'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 infant from the workplace immediately.

I have discussed this plan with my supervisor. I understand that I can bring my infant to the workplace upon final approval of this plan by the Administrator (or Designee) of the Division of _____. If my plan changes, I agree to complete a revised plan for discussion and approval.

Submitted by:

_____ _____

Signature of Parent/Employee Date

Approved by:

Signature of Supervisor	Date
Signature of Administrator (or Designee)	Date

Supervisory/Administrator Comments: _____

Distribution after all signatures have been obtained:

Original: Agency Personnel File
Copy: Supervisor
Employee