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| [ ]  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 #: |       |
|  |  |
| Infant’s Name: |       | Infant’s Date of Birth: |   /  /     | Infant’s Sex: | [ ]  Male [ ]  Female |
| Date Infant Begins Program\*:  |   /  /     | Date Infant Ends Program\*: |   /  /     |
| Please indicate the days and times the infant will be present in the workplace:  |
| Week 1: |
| [ ]  Mon. | Start: | [ ]  Tues. | Start: | [ ]  Wed. | Start: | [ ]  Thurs. | Start: | [ ]  Fri. | Start: |
|        |        |        |        |        |
| End: | End: | End: | End: | End: |
|        |        |        |        |        |
| Week 2 (only needs to be completed if working a 9/80 schedule): |
| [ ]  Mon. | Start: | [ ]  Tues. | Start: | [ ]  Wed. | Start: | [ ]  Thurs | Start: | [ ]  Fri. | Start: |
|        |        |        |        |        |
| End: | End: | End: | End: | End: |
|        |        |        |        |        |
| **\***Infant 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 – Alternate Care Providers**  |
| The following persons have agreed to be Alternate Care Providers (ACP), responsible for providing care for my infant in the workplace, when I become temporarily unavailable to provide care. Provider care is generally not to exceed 1 hour within a shift unless approved by the ACP’s supervisor. Approved Alternate Care Provider agreements must be submitted with this Individual Care Plan.  |
| Primary Alternate Care Provider Name:  |       | Division and Office: |       |
| Work Phone: |       | Cell Phone: |       |
| Secondary Alternate 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. This should include acknowledgement that you have discussed with your supervisor the process to be used to determine when it is appropriate to bring your infant to meetings, and a description of the agreed upon process.  |
|       |
| **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 IAW Policy 2.34. I understand and agree to comply with the terms and conditions set forth in the 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 criteria, whether the criteria are set forth in the policy and procedures, my eligibility may be terminated, requiring me to remove my infant from the workplace.I acknowledge that OFM may terminate this agreement with or without cause, or cancel the program in part or in its entirety, with or without cause, requiring me to remove my baby from the workplace. 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 appropriate Assistant Director. If my plan changes or if I am required to make any adjustments, I agree to complete a revised plan for discussion and approval.  |
| Employee Signature:  |       | Date: |       |
| **Part 6 – Additional Attachments** |
| The following have been approved and/or signed:   |  |
| Individual Care Plan  | [ ]  Yes [ ]  No |
| Care Provider Agreements  | [ ]  Yes [ ]  No  |
| Waiver of Liability form  | [ ]  Yes [ ]  No |
| Workstation Inspection forms from Parent and ACPs  | [ ]  Yes [ ]  No |
| **Part 7 – Approval** |
| Supervisor Signature: |       | Date |       | [ ]  Approved[ ]  Denied\* |
| Manager Signature (if applicable): |       | Date |       | [ ]  Approved[ ]  Denied\* |
| Asst. Director Signature: |       | Date |       | [ ]  Approved[ ]  Denied\* |
| \*Reason for Denial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Distribution: * Original - Employee’s Official Personnel File;
* Copies - AD, Manager (if applicable), Supervisor, Employee
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