Department of Corrections
WASHINGTON STATE

INFANTS AT WORK
ALTERNATE CARE PROVIDER APPLICATION

☐ New ☐ Revised Date: _____

GENERAL INFORMATION

Alternate Care Provider (ACP) name: _____ Personnel ID number: _____
Work phone: _____ Cell phone: _____ Email address: _____
Division/facility/office: _____ Manager/supervisor name: _____
Building address: _____

Parent/legal guardian name: _____ Manager/supervisor name: _____
Work phone: _____ Cell phone: _____ Email address: _____
Estimated program begin date: _____ Estimated program end date: _____

Indicate the days and times you will act as an Alternate Care Provider (ACP).

Week 1				
☐ Monday Start: _____ End: _____	☐ Tuesday Start: _____ End: _____	☐ Wednesday Start: _____ End: _____	☐ Thursday Start: _____ End: _____	☐ Friday Start: _____ End: _____
Week 2 (only needs completed if working a 9/80 schedule)				
☐ Monday Start: _____ End: _____	☐ Tuesday Start: _____ End: _____	☐ Wednesday Start: _____ End: _____	☐ Thursday Start: _____ End: _____	☐ Friday Start: _____ End: _____

ACP AGREEMENT

- I understand that being a care provider does not relieve me of my responsibilities as a Department employee. 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.
- When necessary, I will provide care for the infant indicated above when the parent indicated above is unavailable. My care will not exceed one hour in a 4 hour period.
- If the infant becomes overly disruptive to other employees, I will take the infant to a designated quiet room.
- I understand that the parent may not leave the infant in my care if s/he is going to leave the building.
- I understand that there is another designated care provider, _____ that I may contact for assistance.
- I understand that no other persons besides the parent, myself, and the other designated provider are responsible for the infant once the infant has been placed in my care. If another employee asks to take care of or hold the infant, I will first get the parent's approval.
- I will give the parent at least 2 weeks' notice if I should decide that I no longer wish to be a care provider.

I acknowledge that I have read, understand, and agree to the terms of the ACP Agreement.

_____	_____	_____
ACP name	Signature	Date
_____	_____	_____
Parent name	Signature	Date

DECISION

☐ Approved ☐ Denied

Manager/Supervisor name	Signature	Date

☐ Approved ☐ Denied

Appointing Authority name	Signature	Date

Reason for denial:

Comments:

HUMAN RESOURCES REVIEW

This request complies with the Infant at Work Program procedures. ☐ 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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