



State of New Hampshire

Charles M. Arlinghaus
Commissioner
(603) 271-3201

DIVISION OF PERSONNEL
Department of Administrative Services
State House Annex — 28 School Street
Concord, New Hampshire 03301

Lorrie A. Rudis
Director
(603) 271-3261

Infants in the Workplace Program

PARENT APPLICATION

About this form: This form is used by an employee when requesting to participate in the Infants in the Workplace program.

Parent: Complete this form and submit it to your HR Office, along with the Waiver of Liability form and Care Provider Agreement form.

GENERAL INFORMATION			
Last Name:	First Name, Middle Initial:	Email:	Work Phone:
Location (Building/Cubicle or Office):	Department:	Supervisor's Name:	
Infant's Name:	Infant's Date of Birth:	Plan Type Initial *Revised *If revised, effective date:	
Date Infant Begins Program*:		Date Infant Ends Program*:	
CARE PROVIDER INFORMATION			
Care Provider Name:	Department/Office:	Work Phone:	Email:
ALTERNATE CARE PLAN AND OTHER RELEVANT INFORMATION			
Include alternate child care provider information including name/address and any other relevant plan information or requirements:			
<p>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. I acknowledge I have reviewed CDC and State of New Hampshire immunization policy information and am compliant with the relevant guidelines.</p> <p>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.</p> <p>I understand that I can bring my infant to the workplace upon final approval to participate in the program by Human Resources and the Division of Personnel. If circumstances require a change to this agreement, I agree to complete a revised application for discussion and approval. I understand the State of New Hampshire will attempt to return a response to this application within 30 calendar days.</p>			
Parent Signature:			Date
EMERGENCY CONTACTS			
Contact Name:	Relationship:	Primary Phone:	Email:
Contact Name:	Relationship:	Primary Phone:	Email:



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APPROVAL		
Human Resources Signature:	Date:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied*
Appointing Authority Signature:	Date:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied*
*Reason for Denial: Safety Concern Performance Issue Other (specify below):		
DIVISION OF PERSONNEL REVIEW		
Division of Personnel/Director Signature:	Date:	Approved Denied*
*Reason for Denial: Safety Concern Performance Issue Other (specify below):		
ATTACHMENTS AND NOTIFICATIONS		
<ul style="list-style-type: none"> Care Provider Agreements Waiver of Liability 		