DAUPHIN COUNTY
PENNSYLVANIA
WORK RELEASE
Matthew A. Miller, Director
919 Gibson Blvd. Steelton, Pa. 17113
Phone: 780-7002 Fax: 558-9672

Dauphin County – Direct Commitment Instructions

1. Complete the attached Direct Commitment Intake Form and return it to the Work Release Coordinator via fax (717-558-9672) or email to jcoleman-cobb@dauphinc.org as soon as possible or at least two weeks prior to your commitment date.
2. Contact the Dauphin County Work Release Center Coordinator, Jennifer Coleman-Cobb, at 717-780-6976 or email jcoleman-cobb@dauphinc.org to confirm receipt of you intake form and notice/confirmation of your report date.
3. You must complete a physical, to include a TB/PPD (Tuberculosis) Test, within 90 days prior to your commitment date. You must have your physician complete the attached Health Assessment Form and return it to the Work Release Coordinator via fax (717-558-9672) or email to jcoleman-cobb@dauphinc.org as soon as possible or at least two weeks prior to your commitment date. The health assessment can be completed at your primary care physician or an authorized health care provider such as:

Concentra		**Worknet**	
4200 Union Deposit Road	4910 Ritter Road	6301 Grayson Road	6108 Carlisle Pike
Harrisburg PA 17111	Mechanicsburg PA 17055	Harrisburg PA 17111	Mechanicsburg PA 17055
717-558-6708	717-795-1819	717-920-5910	717-691-9560
Cost: $37.50 TB Test/ $79.50 Physical (as of 09/2015)		**Cost** $15.00 TB Test/ $75.00 Physical (as of 09/2015)	
Hours: Mon – Fri 8a-8p, Weekends 9a-3p (HBG OFFICE)		Hours: Mon – Fri 8a-5p	

You are responsible for all costs associated with completion of the health assessment. Failure to complete the health assessment will result in you being committed to Dauphin County Prison until you are medically cleared. You will be responsible for reimbursing DCP for all costs associated with completion of the health assessment.

4. When reporting to the Work Release Center you must bring with you a maximum of 5 changes of clothes, 3 pairs of shoes, toiletries (new and unopened), and a one week supply of groceries (new and unopened). You **CAN NOT** bring any beverages or products containing alcohol (mouthwash, cologne, and cough syrup). Narcotics prescribed by your doctor are not permitted to be taken at any time while in the Work Release Center. Bring no more than $50 in cash. Cell phones and tobacco products of any kind are strictly prohibited on Work Release property.

Commitment Date ____/____/____ (Tuesday or Thursday)

You must report to the gate of the Work Release Center by 9:00 am.

Bring with you your personal items, a copy of your Health Assessment and Court Order. Upon arrival you will undergo an orientation process and you should inform your employer that you may not be able to attend work until the next business day. **Failure to report as directed or report under the influence of alcohol/drugs will result in your commitment to Dauphin County Prison** pending a directive from the sentencing Judge.

If you have any further questions please contact the Work Release Coordinator, Jennifer at 717-780-6976.

Dauphin County Work Release Center

Direct Commitment Intake

Dauphin County Cases

Defendants Full Name:
First: _____ Middle: _____ Last: _____

Commitment/Report Date: ____/____/____ **Sentencing Judge:** _____

Docket Number/Charge/Sentence: _____

Sex: ☐ Male ☐ Female **Date of Birth:** ____/____/____ **Religion:** _____

DCP #: _____ **Social Security Number:** _____-_____-_____

Defendant's Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Defendants Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Distinguishing Marks: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Home Phone Number: (____) _____-_____ Cell Phone Number: (____) _____-_____

Employer Name: _____ Job Title: _____

Employer Address: _____ City: _____ State: ___ Zip: _____

Supervisor's Name/ Job Title: _____

Employer Phone Number: (_____) _____-_____ Ext. _____

Rate of Pay: $_____ ☐ Per Hour ☐ Per Week & Length of Employment: _____

Were you ever in Work Release: ☐ Yes ☐ No (If Yes, When & Why): _____

Prior Work Release Violation: ☐ Yes ☐ No (If Yes, Why): _____

Are you current on Probation/Parole: ☐ Yes ☐ No (If Yes, Where & Why): _____

Notes: _____

_____

DAUPHIN COUNTY WORK RELEASE CENTER

HEALTH ASSESSMENT FORM

NOTE: This form must be completed only by a licensed medical provider and must be placed in a sealed envelope addressed "ATTENTION MEDICAL PROVIDER"

Date of Assessment: _____

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Insurance Information

Name of Health Insurance Co. _____ Policy#: _____

Group No: _____ Are Referrals Needed for Care: Yes_____ No_____

MEDICAL HISTORY AND PHYSICAL EXAM

Review of System – **Indicate problem in comment section:**

Y	N	System	Comment	Y	N	System	Comment
		Headache				Anemia	
		Seizures				Bleeding	
		Blackouts				Bruising	
		DT's				Arthritis	
		Skin				Gout	
		Hearing				Back Pain	
		Ears				Kidney/bladder	
		Vertigo				Gonorrhea	
		Vision				Chlamydia	
		Speech				Syphilis	
		Dental				Herpes	
		Chewing Problem				Crabs/Lice	
		Swallowing				HIV/AIDS	
		Joint Problems				Prostate	
		Muscle				Hernia	
		Ulcers				**Breast**	
		Gallbladder				**Vaginal Discharge**	
		Hepatitis & Type				**Menarche Age**	
		Hemorrhoids				**LMP / Duration**	
		Thyroid				**Cycle / Flow**	
		Diabetes				**Pregnancies**	**G:** **P:**
		Allergies				**Miscarriages/Abortions**	
		Hay Fever				**Pregnancy Complications**	
		Asthma				**Mammogram Date:**	
		Pneumonia				**Contraceptive Use/Type**	
		Heart Disease				**UTI / Pelvic Infections**	
		Hypertension				**Pregnant Now?**	
		Edema Swelling				**Pregnant Test?**	(+) (-)

Any other known/chronic conditions not listed above:

_____

_____

Tuberculosis Testing:

Previous Testing: Yes: _____ No: _____ Results: _____mm

Past Positives: Date: _____ Location: _____ (***Past Positives MUST be verified***)

Date PPD Planted	Nurses Initials	Date Read	Nurses Initials	Reaction 10mm or > = CXR	CXR Date	Results of CXR
				MM		

Immunizations with Date of Last Vaccine/Dose:

Tetanus: _____ Hepatitis B: _____ Rubella: _____

Pneumovax: _____ Flu: _____ (Other: _____ Date: _____)

Vital Signs at Time of Assessment:

Blood Pressure: _____ Temperature: _____ Pulse: _____

Respiration: _____ Height: _____ Weight: _____

Any Psychiatric, Mental Health and/or Intellectual Disabilities Concerns: Yes ☐ No ☐

If Yes, explain: _____

Currently on any medication: Yes ☐ No ☐ If yes, name of medication and dosage: _____

_____

Physical:

Mark "N" if normal and "A" if abnormal in the box in front of the appropriate area and explain abnormalities.

		(Comments)			(Comments)
	Alert, oriented, co-op			Upper Ext.	
	Head, Scalp, face			Pulses	
	Eyes (EOMI, PERRLA)			Spine	
	Eyes (Sclera, Trauma)			Lower Ext.	
	Ears			Feet	
	Nose Lips, Gums, Teeth			GU System	
	Neck (masses, supple)			Lymph	
	Thorax			Skin	
	Lungs			Gait Balanced	
	Heart			HEARING	AD: AS: AU:
	Abdomen (GI)			VISION	OD: OS: OU:

Comments: _____

_____

Currently on any medication: Yes ☐ No ☐ If yes, name of medication and dosage: _____

_____

Any scheduled or recommended follow-up care or treatment: Yes ☐ No ☐

If Yes: Where: _____ Date: _____ Time: _____

Provider Name (*Printed*): _____ **License #:** _____

Signature: _____ **Specialty:** _____

Primary Care Physician: _____ Telephone: _____

Address: _____