DAUPHIN COUNTY
PENNSYLVANIA
WORK RELEASE

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Dauphin County – Direct Commitment Instructions

1. Complete the attached **Direct Commitment Intake Form** and return it to the Work Release Center Coordinator, Jennifer Coleman-Cobb via fax: 717-780-7371 or email: jcoleman-cobb@dauphincounty.gov as soon as possible or at least two weeks prior to your commitment date.
2. **Contact the Work Release Center** (WRC) to confirm receipt of your intake form & confirmation of your report date *(which MUST be a Tuesday or Thursday at 12:30pm)*; **via phone:** Jennifer Coleman-Cobb 717-780-6976 / Megan Peacock 717-780-7028 or **via email:** jcoleman-cobb@dauphincounty.gov / mpeacock@dauphincounty.gov.
3. You MUST have a physical and TB/PPD (Tuberculosis) Test completed prior to your commitment date and your physician complete the attached **Health Assessment Form**. The TB/PPD Test must be completed within 60 days prior to your commitment date.

   NOTE: A TB/PPD Test needs to be planted and then you must return in 48 to 72 hours to have the test read. You can NOT wait until last minute or the day before you are to report to have this done!

   NOTE: Prescription Narcotics as well as some other prescription drugs with the potential for abuse are **NOT** permitted to be taken at any time while you are a resident in the WRC. You will need to talk to your doctor about an alternative.
4. You MUST have a **COVID-19 Test** completed prior to commitment date. The COVID-19 Test must be completed within 7 days prior to your commitment date.

Send your completed Health Assessment form and Negative COVID-19 results to the WRC via the above email addresses or via fax at 717-780-7371 as soon as possible or at least 1 week 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: $52.00 TB Test/ $90.50 Physical		**Cost** $25.00 TB Test/ $75.00 Physical	
Prices are Subject to Change without Notice		***Prices are Subject to Change without Notice***	
Hours: Mon – Fri 8a-8p, Weekends 9a-3p (HBG OFFICE)		Hours: Mon – Fri 8a-5p	

Commitment Date: ____/____/____

You must report to the Work Release Center by 12:30pm.

Your Commitment Date **MUST be a **Tuesday** or **Thursday** at 12:30pm – if it is not – CONTACT YOUR ATTORNEY**

Report with your PA ID (or photo ID), a copy of your Health Assessment, a copy of any court papers, and your personal items. Upon arrival you will undergo an intake/orientation process before being permitted out of the center. You should inform your employer that you may not be able to attend work until the next business day.

Failure to report as directed and/or reporting without the proper paperwork or with drugs/alcohol in your system, could result in your commitment to the Dauphin County Prison!

(Pending a directive from the sentencing Judge or until medically cleared)

(YOU WILL BE DRUG & ALCOHOL TESTED)

- Personal Items to **bring** with you to WR: a maximum of 5 changes of clothes, 3 pairs of shoes, and $60 cash. Bring your toiletries *(new & unopened)* and a one-week supply of groceries *(new & unopened)*.
- Do NOT bring any beverages or products containing alcohol *(mouthwash, cough syrup, etc.)*. Cell phones and tobacco products of any kind are strictly prohibited on Work Release property.
- Do NOT report with your vehicle, you must receive Director approval to be permitted to drive while in the Work Release Center *(even if your license is valid and when off WR property)*.

You may find additional WR paperwork, rules, and information at www.dauphincounty.org under Government / Courts / Online Forms / Direct Commitment Packet *or* Female/Male Resident Guide.

Dauphin County Work Release Center
Direct Commitment Intake
Dauphin County Cases

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

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

Docket Number/Charge/Sentence: _____

Date of Birth: _____ /_____ /_____ **Social Security Number:** _____-_____-_____

DCP #: _____ **SID**:_____ **Sex:** ☐ Male ☐ Female **Religion:** _____

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: _____ Job Title/Position: _____

Supervisor's Name/ Job Title: _____

Supervisor Email: _____Phone: (____)_____-_____ Ext. _____

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

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: _____