

**SISKIYOU COUNTY SHERIFF'S OFFICE**  
**JEREMIAH LARUE, SHERIFF**  
 SHERIFF'S INMATE WORK ALTERNATIVE PROGRAM  
 DAY REPORTING CENTER  
 805 JUVENILE LANE, YREKA, CA. 96097  
 530-841-4352

## APPLICATION FOR WORK PROGRAM

<b>Applicant Name (Last, First, Middle)</b>				<b>Race</b>	<b>Birthdate</b>	<b>Age</b>
<b>Home Address</b>		<b>Apt#</b>	<b>City</b>	<b>Zip</b>	<b>Home Phone#</b>	<b>Cell Phone#</b>
<b>Social Security Number</b>	<b>Sex</b>	<b>Height</b>	<b>Weight</b>	<b>Eye Color</b>	<b>Hair Color</b>	
<b>Driver's License #</b>	<b>State</b>	<b>License Status</b> Valid    Suspended    Revoked    Restricted			<b>Place of Birth</b>	
<b>Marital Status</b> Married    Divorced    Separated    Single		<b># of Children</b>	<b>Ages of Children</b>		<b>Lives with you</b> Yes    No	
<b>Emergency Contact</b>	<b>Phone Number</b>	<b>Address</b>			<b>Relationship</b>	
<b>Are you on Probation?</b> YES    NO			<b>Probation Officer Name/Contact Information</b>			
<b>County of Probation -</b>						
<b>Means of Transportation to crew meeting site</b>						

### INSTRUCTIONS FOR FILLING OUT YOUR APPLICATION

Be completely honest with your answers. Failure to tell the truth may result in denying your application for the Sheriffs Inmate Work Crew Program. Make sure **ALL** the requested information to the best of your ability. If the questions is not applicable, or the answer is unknown, state so. Do not leave any question blank. If you fail to complete all information requested on this application, it may result in a delay or denial to the program.

### OFFICE USE ONLY

**Date Submitted** \_\_\_\_\_

**Approved By** \_\_\_\_\_

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**Participant Agreement**

1. I understand that I am participating on the work crew in lieu of completing my jail sentence in Jail or to complete my community work service hours. \_\_\_\_\_ **Initial**
2. I will appear at 8:00 AM at the Day Reporting Center ready for work. I will be dressed in long pants, work type boots and an appropriate shirt and/or jacket for weather conditions. \_\_\_\_\_ **Initial**
3. I will not violate any laws or jail rules. If I have any contact with any Law Enforcement Agency, I will report such contact as soon as possible to the Day Reporting Center (DRC) Staff. I will submit my person, places, and things under my custody or control, or in which I have an interest, to search and seizure by any Peace Officer at any time of the day or night with or without probable cause, and with or without a warrant. \_\_\_\_\_ **Initial**
4. I will comply with all terms and conditions of my probation supervision (if any) and any directives issued by my probation officer or agent of the Probation Department. Failure to abide with any of these orders may result in my immediate removal from worker status. \_\_\_\_\_ **Initial**
5. I will not consume or possess any alcoholic beverages, illegal drugs or narcotics. I will advise the DRC staff of any prescription drugs I am required to take. I will bring all necessary medications/medical appliances that I need with me. All medication use during work hours will be with the approval of medical staff and the crew supervisor. \_\_\_\_\_ **Initial**
6. Appearing for work while under the influence of alcohol or drugs will result in my immediate dismissal from the program and confinement in the county jail. \_\_\_\_\_ **Initial**
7. I will submit to any chemical, blood, breath, saliva or urine testing deemed necessary by DRC staff and/or any Peace Officer. \_\_\_\_\_ **Initial**
8. No persons that are not assigned to the work crew may join or meet me during the work hours of the crew. \_\_\_\_\_ **Initial**
9. Weapons and/or drugs are prohibited while assigned to the Day Reporting Center. Possession of such items subject me to arrest. \_\_\_\_\_ **Initial**
10. Any items found during the course of my work will be immediately turned over to the Work Crew Supervisor. I may not keep any items that I find in the course of my work with the Inmate Work Crew. \_\_\_\_\_ **Initial**
11. I will abide by any reasonable requests and instructions of the DRC staff. \_\_\_\_\_ **Initial**
12. I will be financially responsible for any medical expenses incurred outside of the working hours of the Inmate Work Crew while participating in the Work Program. \_\_\_\_\_ **Initial**
13. I will immediately report all injuries or changes in my health to DRC staff. \_\_\_\_\_ **Initial**

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14. I will immediately notify the DRC staff if I am unable to attend work. I understand that the only reason for missing work is sickness, court appearances, or pre-scheduled employment will constitute an excused absence. I further understand that I will be required to produce written documentation addressing the reason for my absence. All scheduled time off needs to be approved by DRC staff and a Time Off request slip needs to be filled out. \_\_\_\_\_ **Initial**
15. I understand that I will not be given credit toward my sentence for excused absences. \_\_\_\_\_ **Initial**
16. I understand that unexcused absences will not result in credit toward my sentence and that unexcused absences may result in **loss of good time** or dismissal from the program and incarceration in the county jail. \_\_\_\_\_ **Initial**
17. I understand that excessive absences, as determined by the DRC staff, whether excused or unexcused may result in my dismissal from the program and incarceration in the county jail. \_\_\_\_\_ **Initial**
18. I will participate in programs offered by Jail Programs staff; this includes Drug and Alcohol, Anger Management, Interactive Journaling, Individual Therapy and any other programs that staff feels would aide in my rehabilitation. Failure to participate could result in sanctions up to and including removal from the work crew. \_\_\_\_\_ **Initial**

I, \_\_\_\_\_, having been accepted to participate in the Sheriff's Work Alternative Program, understand I must comply with the foregoing rules and regulations. I also acknowledge and agree that if I violate any of these conditions, I may be subject to disciplinary actions, which may include removal from the Sheriff's Alternative Work Program and/or remand into Siskiyou County Jail. I further understand and acknowledge that leaving the job and/or failing to report as ordered to the Day Reporting Center will constitute escape and I may be arrested and charged Pursuant to section 4532 of the California Penal Code.

\_\_\_\_\_  
Participant's Signature

Approved by:

\_\_\_\_\_  
Program Staff

\_\_\_\_\_  
Date

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**MEDICAL QUESTIONNAIRE**

As a participant in the Sheriff's Inmate Work Crew you will be expected to complete strenuous physical activity for extended periods of time in all weather conditions.

Please complete the following questionnaire and explain all yes answers. Your answers will be reviewed by jail medical staff and you may need to obtain a clearance from your physician before you will be accepted into the program.

	<b>Yes</b>	<b>No</b>
Are you now or have you ever been treated for mental or emotional problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever thought seriously about suicide or attempted Suicide? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcohol or drugs? If yes, what kinds? How much? How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you now or have you ever used needles? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any developmental disabilities? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been treated for Hepatitis, STD's, HIV/AIDS, Lice/Scabies? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been treated for TB? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have persistent cough, excessive fatigue, unexplained weight loss, fevers, or sweats? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you been exposed to anyone that may have a contagious disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
In the last 10 days have you had a fever, cough, aches, vomiting, or diarrhea? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medication? If yes, please list all medications. _____	<input type="checkbox"/>	<input type="checkbox"/>

## MEDICAL QUESTIONNAIRE – Page 2

	Yes	No
Do you have or been treated for Heart Disease or High Blood Pressure? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been treated for any lung problems? Asthma, Emphysema COPD? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been treated for liver or kidney problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been treated for Cancer? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been treated for epilepsy, convulsions, or a seizures disorder? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been treated for Diabetes? If yes do you use insulin? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or rashes on your body? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is there any reason that you would be unable to perform strenuous outdoor work? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to lift/carry 10lbs. without assistance? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to stand/walk for extended periods of time? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use or need any assistive devices? (hearing aids, canes, crutches etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you been treated for any skin infections such as MRSA or Staph? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been treated for Hemophilia (Bleeding Disorder)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been treated for any dental pain or infections? _____	<input type="checkbox"/>	<input type="checkbox"/>

# MEDICAL QUESTIONNAIRE – Page 3

Yes No

Do you have any environmental, food or medication allergies? If yes, please explain.  
\_\_\_\_\_.

Do you have any food restrictions or a special diet?  
\_\_\_\_\_.

Are you under a Doctor's care, including Mental Health Care? If yes, provide Doctor's Contact information.  
\_\_\_\_\_.

Are you pregnant or have you delivered a baby in the last 6 weeks?  
\_\_\_\_\_.

Do you have any Health problems other than what you have already stated?  
\_\_\_\_\_.

Completed By: \_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

## OFFICE USE ONLY

Reviewed By: \_\_\_\_\_  
(Printed Name/Title)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Initials

Subject is medically cleared for participation in the Sheriff's Work Alternative Program.

Subject must produce additional documentation for clearance (Please specify).  
\_\_\_\_\_.

Subject is not medically cleared for participation in the Sheriff's Work Alternative Program.