

SISKIYOU COUNTY SHERIFF'S OFFICE
JON E. LOPEY, SHERIFF
SHERIFF'S INMATE WORK CREW PROGRAM
315 S. OREGON STREET, YREKA, CA. 96097
530/842-8156 FAX 530/842-1507

Participant Agreement

1. I will not violate any laws. If I have any contact with any law enforcement agency, I will report such contact as soon as possible to the Inmate Work Crew Program staff.
2. I will comply with all terms and conditions of my probation (if any) and any directives issued by my probation officer. Failure to abide with any of these orders may result in my immediate removal from the program.
3. I will not consume or possess any alcoholic beverages, illegal drugs or narcotics. I will advise the Inmate Work Crew 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 the Jail Medical Staff and the crew supervisor. I further understand that I may not possess or use any non-prescription medications during working hours.
4. 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.
5. I will submit to any chemical, blood, breath, saliva or urine testing deemed necessary by the Inmate Work Crew staff.
6. No persons that are not assigned to the work crew may join or meet me during the work hours of the crew unless prior permission is obtained from the Inmate Work Crew staff.
7. I will not have any weapons or contraband with me during any time I am assigned to the Inmate Work Crew.
8. 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.
9. Applicant must be a Siskiyou County resident and stay physically present in Siskiyou County for the duration of the program. I will immediately notify the crew supervisor of any change to my address and/ or phone number.
10. I will abide by any reasonable requests and instructions of the Work Crew staff.
11. I will be financially responsible for any medical expenses incurred outside of the working hours of the Inmate Work Crew while participating in the Inmate Work Crew Program.
12. I will immediately notify the Inmate Work Crew staff if I am unable to attend work. I understand that the only missing work for sickness, court appearances, or at the direction of my probation officer will constitute an excused absence. I further

understand that it will be required that I produce written documentation from a medical doctor, the court, or my probation officer upon my return to the program.

13. I understand that I will not be given credit toward my sentence for excused absences.
14. I understand that unexcused absences will not result in credit toward my sentence and that unexcused absences may result in the loss of good time/ work time credits.
15. I understand that excessive absences, as determined by the crew supervisor, whether excused or unexcused may result in my dismissal from the program and incarceration in the county jail.
16. I will immediately report all injuries or changes in my health to the Inmate Work Crew supervisor.
17. I will appear at 8:00 AM at the crew meeting spot ready for work. I will be dressed in long pants, work type boots that extend above the ankle, and an appropriate shirt/ jacket for conditions/ project.
18. I will use all safety equipment provided.

I, _____, having been accepted to participate in the Sheriff's Inmate Work Crew Program, understand I must comply with the foregoing rules and regulations. I also understand and agree that if I violate any of these conditions, I may be subject to disciplinary actions, which may include my removal from the program without notice or immediate remand into the jail for completion of my sentence. I further understand that leaving the job will constitute escape and I may be prosecuted for this new charge.

Participant's Signature

Date

Deputy Sheriff, Program Staff

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APPLICATION FOR WORK CREW

NAME OF APPLICANT (LAST, FIRST, MIDDLE)				RACE	BIRTHDATE	AGE
HOME ADDRESS		APT#	CITY	ZIP	HOME PHONE	CELL PHONE
SOCIAL SEC. NUMBER	SEX MALE FEMALE		HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR
CALIFORNIA DR. LICENSE#		LICENSE STATUS VALID SUSP. REVOKED RESTRICTED		PLACE OF BIRTH		
CITIZEN OF WHAT CO.			ALIEN REGISTRATION#	PLEASE NOTE: IF YOU ARE NOT A CITIZEN OF THE UNITED STATES, YOU WILL BE REQUIRED TO BRING YOUR IMMIGRATION REGISTRATION WITH YOU AT THE TIME OF YOUR APPOINTMENT AND/OR INTERVIEW.		
MARITAL STATUS MARRIED DIVORCED SEPERATED SINGLE			# OF CHILDREN	AGE(S) OF CHILDREN	LIVE WITH YOU YES NO	
EMERGENCY CONTACT:			PHONE #	ADDRESS	RELATIONSHIP	
ARE YOU ON PROBATION Y / N COUNTY YOU ARE ON PROBATION:				PROBATION OFFICER NAME / CONTACT INFO		
MEANS OF TRANSPORTATION TO CREW MEETING SITE:						

INSTRUCTIONS IN FILLING OUT YOUR APPLICATION

Be completely honest in your answers. Failure to tell the truth may result in denying your application for this program. Make sure you answer **ALL** the requested information to the best of your ability. If the question is not applicable, or the answer is unknown, state so. Do not leave any questions blank. If you fail to complete all information requested on this application, it may result in a delay or denial to the program. Please refer to the 'Information Packet' and 'Agreement Sheet' that accompany this application for complete instructions.

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OFFICE USE ONLY

TRANSFER	OUT	IN
COUNTY		

SHERIFF'S ID# _____ DATE SUBMITTED _____ STAFF _____

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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.

	Yes	No
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, or 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 a 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 has fever, cough, body aches, vomiting, or diarrhea? _____	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL QUESTIONNAIRE page 2

Yes No

Do you take medication? If yes please list all medications?

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Do you have or have you been treated for Heart Disease or High Blood Pressure?

--	--

Do you have or been treated for any lung problems? Asthma, Emphysema, COPD

--	--

Do you have or been treated for liver or kidney problems?

--	--

Do you have or been treated for Cancer?

--	--

Do you have or been treated for epilepsy, convulsions, or a seizure disorder?

--	--

Do you have or been treated for Diabetes? If yes do you use insulin?

--	--

Do you have any sores/ rashes on your body?

--	--

Do you have any conditions that limit you ability to perform strenuous outdoor work?

--	--

Are you able to lift/ carry 10 lbs. without assistance?

--	--

Are you able to stand/ walk for extended periods of time?

--	--

Do you use/ need assistive devices? (hearing aids, canes, crutches etc.)

--	--

Have you ever been treated for skin infections such as MRSA or Staph?

--	--

Do you have or been treated for Hemophilia (Bleeding Disorder)?

--	--

Do you have or been treated for any dental pain or infections?

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