Rock Nobles Community Corrections

COMMUNITY SERVICE
CLIENT INTAKE FORM

NAME: _____

ADDRESS: _____

PHONE: _____ CELL PHONE: _____

D.O.B. _____ RACE: _____ SEX: _____

SOCIAL SECURITY #: _____ D.L. # _____ _____
(State) (License Number)

SENTENCING COUNTY: _____ FILE #: _____

OFFENSE: _____ OFFENSE DATE: _____

OFFENSE LEVEL: _____ DATE SENTENCED: _____

STATUS IN: Probation Diversion Supervised Release

HOURS ORDERED: _____ COMPLETE DEADLINE: _____

AVAILABLE FOR WORK (Circle Days) S M T W TH F SA

TIME AVAILABLE: From: _____ To: _____

HANDICAPS (Explain): _____

You will be notified by Rock Nobles Community Corrections Office where and when to report for your work site assignment. You will then follow the work schedule assigned by your work site supervisor and probation agent. If for any reason you cannot report as required this office must be notified in advance.

If the above hours are not completed additional sanctions may be imposed.

_____ _____
«C_FullName» «Agt_Fname» «Agt_Lname»
Client Corrections Agent

****

TO BE COMPLETED BY COMMUNITY SERVICE SUPERVISOR:

DATE PERSON BEGAN WORK SERVICE (mm/dd/yy): _____

DATE PERSON COMPLETED WORK SERVICE (mm/dd/yy): _____
HOURS COMPLETED:_____

OFFENDER MEDICAL INFORMATION SHEET

NAME: _____ D.O.B _____ SOC SEC#: _____

ADDRESS: _____

TELEPHONE: _____ CELL PHONE: _____

FILE#: «CC_Num»

EMERGENCY CONTACT PERSON:
_____TELEPHONE:_____

To assist with job or task assignment, check the following if you have had or are now experiencing:

☐ Poison Ivy Allergy	☐Frostbite	☐Allergic to Bee Stings
☐Epilepsy	☐Other Allergies	☐Diabetes
☐Fainting or Blackout	☐Asthma	☐Heart Trouble
☐Now Pregnant	☐Heat Stroke	☐HIV Positive
☐ Hemophilia	☐Cancer	☐Back Injury

☐Other Disabilities/Impairment

I DO☐ I DO NOT☐ have a medical restriction that limits the type of community service work that I can perform. If so, please explain: _____
_____

Identify any/all medication you are currently taking:_____

I AM☐I AM NOT☐ currently under a doctor's orders reqarding work.
If so, please explain: _____

Physician: _____ Clinic: _____

Clinic Phone: _____ Are you presently receiving Medical Assistance?
_____ Do you have health insurance?_____
Health Insurance Company: _____

I understand that if I am injured while performing community service work I MUST notify my crew leader IMMEDIATELY. I also understand that my medical insurance must be used to pay for medical costs. If I do not have any medical insurance or I have costs that are not covered by insurance, I must contact my crew leader within 30 days of the date of the injury to file a claim or otherwise I will assume full responsibility for my medical costs.

I declare under penalties that I have examined this document and that it is true, correct and complete to the best of my knowledge and belief.

Signature _____Date: _____

Coordinator/Agent: _____Date: _____
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