DAUPHIN COUNTY
PENNSYLVANIA
WORK RELEASE
Matthew A. Miller, Director
919 Gibson Blvd. Steelton, Pa. 17113
Phone: 717-780-7002 Fax: 717-780-7371

Dauphin County – Direct Commitment Instructions

1. **Contact the Work Release Center** (WRC) to confirm receipt of your court order and 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.
2. Complete the attached **Direct Commitment Intake Form** and return it to the Work Release Center Coordinator, Jennifer Coleman-Cobb via email: jcoleman-cobb@dauphincounty.gov or fax: 717-780-7371 as soon as possible after sentencing or (*preferably*) at least two weeks prior to your commitment date.
3. **You MUST have a Physical** and **TB/PPD** (Tuberculosis) **Test COMPLETED** prior to your commitment date and **your physician fill out** the attached **Health Assessment Form**. The TB/PPD Test must be completed within 60 days prior to your commitment date and physical within 1 year prior to your commitment date.

NOTE: A TB/PPD Test needs to be planted and then you RETURN to the provider 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!

Send a copy of your COMPLETED Health Assessment Form to the WRC via *the above* email addresses or fax as soon as possible or at least 1 week prior to your commitment date and **bring the original** with you when you report.

NOTE: **Prescription narcotics** and **various other prescription drugs** that carry a risk of abuse are **NOT permitted** during your stay at the WRC (***Including**, but not limited to: Gabapentin, Seroquel, & Wellbutrin*). It may be necessary for you to consult with your healthcare provider about a weaning off process or alternative options.

The health assessment can be completed at your primary care physician or an authorized health care provider such as:

Concentra (East Shore Locations)		**Concentra** (West Shore Locations)	
6301 Grayson Road Harrisburg, PA 17111 717-920-5910	4200 Union Deposit Road, Ste. G, H Harrisburg, PA 17111 717-558-6708	6108 Carlisle Pike Mechanicsburg, PA 17055 717-691-9560	4910 Ritter Road Mechanicsburg, PA 17055 717-795-1819

Medical Center Hours: Monday – Friday 8:00 a.m. - 5:00 p.m. (NOTE: TB/PPD Test are NOT Administered on Thursday's)

Prices: $75.00 TB/PPD Test **&** $124.00 Physical

*****Prices are Subject to Change****AND****Insurance May NOT be Accepted*****

Commitment Date: / /

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

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

Report with your PA ID (or photo ID), original Health Assessment Form, a copy of any court papers provided at sentencing, 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 WRC: 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 *(liquid or powder)* or products containing alcohol *(mouthwash, cough syrup, etc.)*.
- 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 WRC property)*.

You may find additional WRC paperwork & information at www.dauphincounty.gov under Courts & Prison (*Top Right, **Click***), Court Departments / Work Release Center / Online Forms / Dauphin County Sentence - Direct Commitment Packet *or* Resident Guide.

*Revised **October 2025***

Dauphin County Cases
Direct Commitment Intake
Dauphin County Work Release Center

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

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

Docket #/Charge/Sentence: _____

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

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

Defendant Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

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

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

Distinguishing Marks: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

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

Employer: _____ Job Title/Position: _____

Supervisor 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, signed, & dated by a licensed medical provide.

Date of Assessment: _____

Patient Full Name: _____

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

Insurance Information

Name of Health Insurance Co. _____ Policy#: _____

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

MEDICAL HISTORY

Review of System – Specify (Y) Problem in Comment Section:

Y	N	System	Comment
		Headache	
		Seizures	
		Blackouts	
		DT's	
		Skin	
		Hearing	
		Ears	
		Vertigo	
		Vision	
		Speech	
		Dental	
		Chewing Problem	
		Swallowing	
		Joint Problems	
		Muscle	
		Ulcers	
		Gallbladder	
		Hepatitis & Type	
		Hemorrhoids	
		Thyroid	
		Diabetes	
		Allergies	
		Hay Fever	
		Asthma	
		Pneumonia	
		Heart Disease	
		Hypertension	
		Edema Swelling	

Y	N	System	Comment
		Anemia	
		Bleeding	
		Bruising	
		Arthritis	
		Gout	
		Back Pain	
		Kidney/bladder	
		Gonorrhea	
		Chlamydia	
		Syphilis	
		Herpes	
		Crabs/Lice	
		HIV/AIDS	
		Prostate	
		Hernia	
		Breast	
		Vaginal Discharge	
		Menarche Age	
		LMP / Duration	
		Cycle / Flow	
		Pregnancies	**G:** **P:**
		Miscarriages/Abortions	
		Pregnancy Complications	
		Mammogram Date:	
		Contraceptive Use/Type	
		UTI / Pelvic Infections	
		Pregnant Now?	
		Pregnant Test?	(+) (-)

Any Personal Medical Devices (assistive/diagnostic/etc.) **Needed** *or* **Other Problems/Chronic Conditions:**

_____

_____

_____

_____

Tuberculosis Testing (*MUST Have Test COMPLETED/Read With-in 90 Days of Report Date*):

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

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

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

Immunizations with Date of Last Vaccine/Dose *(If Known)*:

COVID-19: _____ Flu: _____ Hepatitis B: _____ Rubella: _____

Pneumovax: _____ Tetanus: _____ (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: _____

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

N/A		Comments	N/A		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:

Currently on any **PAIN Medication:** Yes ☐ No ☐ **If Yes,** Name **&** Dosage: _____

Currently prescribed any **BENZOS** (*Benzodiazepines*)**:** Yes ☐ No ☐ **If Yes,** Name **&** Dosage: _____

Currently on any **ADHD Medication:** Yes ☐ No ☐ **If Yes,** Name **&** Dosage: _____

Currently on ANY OTHER **Medication:** Yes ☐ No ☐ **If Yes,** (*List* ALL *Medication*) Name, Dosage, **&** Duration On:

★ **MEDICATION** (*includes but not limited to*) **NOT PERMITTED:** ADHD, Benzos, Narcotics, Gabapentin, Seroquel, **&** Wellbutrin ★

_____

_____

_____

_____

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

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

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

Signature: _____ **Specialty:** _____

Primary Care Physician: _____ Telephone: _____

Address: _____