ATTENTION:
BRING THIS COMPLETED FORM WITH YOU TO JAIL OR YOU WILL BE KEPT IN FULL CUSTODY AND NOT BE ALLOWED TO PARTICIPATE IN WORK RELEASE OR WORK FURLOUGH

MARICOPA COUNTY
CORRECTIONAL HEALTH SERVICES
Self Surrender Office
Lower Buckeye Jail Infirmary
3250 W. Lower Buckeye Road
Phoenix, Arizona 85009
(602) 876-6884
Fax (602) 455-6147

Healthcare Provider's Certification

This form must be completed greater than 7 days and less than 90 days before incarceration to assess whether the person is medically fit to serve time in the Maricopa County Sheriff's Office Con-Tents facility. This form must be completed for all individuals serving Work Release, Work Furlough, or Weekends of 15 days or more.

- **Housing**: Outdoor military type tent dormitory style living space subject to weather conditions, with access to indoor showers and restrooms.
- **Grounds**: Dirt and gravel with limited paved/concrete areas.
- **Medications**: Persons must self administer medications. Storage lockers and refrigerators are available for medication storage.

Determining Medical/Mental Health Fitness:
The following are examples of conditions that render a person *not suitable* to be housed in Con-Tents:
a) Any temporary medical condition such as pregnancy, casts, splints.
b) Severe chronic conditions such as lung disease, heart disease, mental illness.
c) Inability to ambulate unaided (without the use of walker, cane, crutches, wheelchair)
d) Inability to provide for own hygiene
e) Inability to self-administer medications

Requirements for Con-Tents Clearance:
a) Health Assessment
b) Current PPD (within one year), or a negative Chest x-ray with a negative symptom assessment.

If you have additional questions regarding healthcare services available in the jail facilities for the patient named below, please contact the Self-Surrender line at 602-876-6884 and leave a message*. Messages are retrieved and answered during normal business hours, 8:00 am - 4:00 pm, Wednesday through Saturday.*
If you have any questions regarding the exclusion of active contagious TB or other communicable disease, please call Public Health at 602-506-5101.

I certify that; Patient Name ______________________________ Date of Birth ____________________

Address: ____________________________ City ____________ State ________ Zip ______________

Phone (_____)__________________________

Is free of active contagious TB & meets medical/mental health fitness criteria for placement in Con-Tents Facility.
REQUIRED: Tuberculin Skin Test (or comparable test) results: __________ mm; Date: _________ **or**
Negative Chest X-Ray (for TB) Date: ____________________

_______________________________________ _______________________
Signature of Healthcare Provider ☐ MD ☐ DO ☐ NP ☐ PA Date

OR

Does not meet medical/mental health fitness criteria for placement in the Con-Tents facility; individuals who are unable to serve their sentence at "Con-Tents" may be ineligible for work furlough/work release.

_______________________________________ _______________________
Signature of Healthcare Provider ☐ MD ☐ DO ☐ NP ☐ PA Date

Healthcare Provider **Printed** Name: ____

Address/City: ____

Telephone: ____