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

Healthcare Provider's Certification Instructions

This form must:

a) Be completed for all individuals serving Work Release, Work Furlough, or Weekender sentences for more than 24 hours
b) Be completed less than 45 days before incarceration to assess whether the person is medically fit to serve time in the Maricopa County jails
c) Include Current PPD (within six months), or a negative chest x-ray with a negative symptom assessment

Medical Eligibility:

The following are examples of conditions that may make a person ineligible for work furlough or work release programs. Patients with:

a) Medications that may cause alterations in mental status or alertness such as any controlled substances and some mental health medications
b) Uncontrolled chronic or acute illnesses or abnormal vital signs
c) A seizure within the last 90 days
d) Chronic oxygen use
e) High risk or late term pregnancy
f) Recent alcohol or substance abuse at risk for withdrawal
g) Assistive devices such as crutches, wheelchairs, prostheses, canes, walking boots, etc.

If you have additional questions regarding healthcare services available in the jail facilities, please contact the Self-Surrender Line at 602-876-6884 and leave a message. Messages are retrieved daily.

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Healthcare Provider's Certification Form
(See Instructions)

Patient Name: _____ DOB: ___/___/____ Phone: ( ) ____-_____

Address: _____City:_____State:_____Zip:_____

REQUIRED:

Tuberculin Skin Test Results: _____ mm
Date Placed: ___/___/___ Date Read: ___/___/___

Or

Negative Chest X-Ray with Negative Symptom Assessment Date: ___/___/___

Patient meets eligibility qualifications: ☐ YES ☐ NO

By signing, I confirm that this patient is free from active Tuberculosis or any other contagious disease. I also confirm that this patient meets medical and mental health criteria for housing in the Maricopa County Sheriff's Office Jail. Further, I understand that if this patient is actively being treated for any conditions as outlined in the instruction sheet, I continue to assume responsibility as their primary care provider for maintenance and follow up of their active medical conditions.

_____ ☐ MD ☐ DO ☐ NP ☐ PA
Signature of Healthcare Provider

Printed Name: _____ Phone: ( ) ____-_____

Address: _____City:_____State:_____Zip:_____