SUMMIT COUNTY SHERIFF'S OFFICE
DETENTIONS DIVISION
INMATE WORK RELEASE PROGRAM APPLICATION

APPLICANT IDENTIFICATION

NAME: ______________________________ BOOKING #: ______________

COURT DOCKET#: ____________ OTHER PROVISIONS: ____________________

OFFENSE(S): ____

RESTRAINING ORDER: Yes No

SENTENCED TO: ____________ DAYS / MONTHS BY JUDGE: ________________

TOTAL FINE / COURT COSTS: $______________ PAYMENTS DUE: ____________

APPLICANT CONTACT INFORMATION

MAILING ADDRESS:

____

____

PHYSICAL ADDRESS:

____

____

CELL PHONE #(s): ____

EMAIL ADDRESS: ____

EMPLOYMENT

NAME OF COMPANY: ____

PHYSICAL ADDRESS: ____

MAILING ADDRESS: ____

WEB ADDRESS: ____

JOB TITLE/OCCUPATION: _____________________________ PAY: $_________ PER WEEK / HOUR

SUPERVISOR'S NAME: __________________________________ PHONE #: _____________________

SUPERVISOR'S EMAIL ADDRESS: ____

LOCATION OF WORK SITE: ____

WORK SITE PHONE #: ________________________ YOUR CELL PHONE #: ____________________

LIST ANY DRIVING/MACHINE OPERATION: ____

ARE YOU SELF EMPLOYED: Yes No

IF SO, DESCRIBE WHERE YOU WORK AND THE PHYSICAL ADDRESS: _____________________

____

____

MEDICAL

HAVE YOU BEEN COVID VACCINATED: Yes No

PROVIDE A COPY OF YOUR VACCINATION CARD.

MEDICAL INSURANCE PROVIDER INFORMATION:

____

____

MEDICAL DOCTOR'S NAME: ____

LOCATION OF FACILITY: ____

____

____

TRANSPORTATION

MODE: ____ PERSONAL VEHICLE _____ BUS _____ FRIEND _____ WALK

OTHER FORM OF TRANSPORTATION: ____

IF YOU ARE DRIVING A VEHICLE TO WORK, COMPLETE THE FOLLOWING:

ARE YOU REQUIRED TO HAVE AN ACTIVE INTERLOCK DEVICE: Yes No

DO YOU HAVE AN ACTIVE INTERLOCK DEVICE: Yes No

IF SO, PLEASE PROVIDE PROOF THAT THIS IS ACTIVATED.

DRIVER'S LICENSE #: ______________________________________ STATE: _______________

VEHICLE MAKE: _________________________ MODEL: ___________________ YEAR: _________

COLOR: _________________________ LICENSE PLATE # AND STATE: _______________________

OTHER REGISTERED OWNER: ________________________________ PHONE #: _______________

INSURANCE COMPANY: ____

COVERAGE: ________________________________ POLICY #: _______________________________

OFFICE USE ONLY

DRIVER'S LICENSE IS ☐ VALID ☐ REVOKED ______ initials ____________ date

☐ ACTIVE INTERLOCK DEVICE PROOF PROVIDED ______ initials ____________ date