Kern County SHERIFF

WORK RELEASE PROGRAM, PHYSICIAN'S EVALUATION / RELEASE / WAIVER

Participants in the Sheriff's Department, Work Release Program perform manual labor in an outdoor working environment. The typical activities include lifting up to 50 lbs., pulling, bending, utilizing gardening implements, janitorial duties and washing vehicles. The presence of medical or mental health problems could require a release from a licensed physician or could eliminate eligibility for the program altogether. When eligibility based on medical or mental health conditions requires assessment, the information requested on this form will be required. Suitability for the program will be evaluated on a case by case basis. The cost of this medical evaluation is the participant's sole responsibility.

I, _____, hereby authorize the release of any and all medical or mental health records concerning me to a representative of the Kern County Sheriff's Department, Work Release Program exclusively for the purposes set forth herein. The information is necessary to confirm medical conditions, medical/work restrictions, medical forms, medical excuses and the authenticity of medical forms in order to determine my suitability for the Work Release Program. For the purposes of this release only, I hereby waive any privilege I may have concerning these records including, but not limited to, specifically, the psychotherapist-patient privilege covering mental health treatment, if any. This release is made pursuant to the provisions of Civil Code section 56.11 and Welfare and Institutions Code section 5328. The consent here given shall expire one year from the date next to my signature below. I understand that I have a right to receive a copy of this authorization.

Applicant/Participant: _____ Date of Birth:_____
Last First Middle

Applicant/Participant: _____ Date: ____/____/____ Staff Witness _____
Signature (to be signed in front of staff) Initials Badge #

To the physician: Please evaluate and give a diagnosis on the patient's medical/mental condition listed below,

MEDICAL -
MUST BE ABLE TO PERFORM ALL DUTIES LISTED ABOVE WITHOUT ANY RESTRICTIONS

Please have the physician complete the following information:
Date seen by physician: ____/____/____ Date of physical/mental problem onset: ____/___/____ to ___/___/___.
Nature of illness/diagnosis (Please be specific): _____

_____

Prescribed medications: _____

_____

Based on the typical activities listed above please advise the patient's limitations or restrictions if applicable:

_____

Date applicant/participant can return to work with **no restrictions**: _____/_____/____

Physicians Name (Please print): _____ Physicians signature: _____

Physician's Address: _____

Physician's Phone Number (_____)_____ Date: ____/___/____

Physician's office stamp:

(Rev. 8-5-25)