

ADULT OFFENDER WORK PROGRAM APPLICATION

(Please ACCURATELY complete all requested information)

Full Name: _____ D.O.B.: _____

Case number: _____

Addresses: (Mailing) _____

Physical: _____

E-mail Address: _____

Phones: Cell: _____ Home : _____ Message: _____

What will be your transportation to the Work Sites (all sites are in Marin County)? _____

Occupation and/or Skills: _____

If not employed, how do you support yourself? _____

Do you have any physical limitations that would prevent you from doing manual labor for 8 hours a day?

Yes No If YES, describe it: _____

Are you currently under a doctor's care? Yes No If YES for what? _____

Are you taking any medication? Yes No If YES, list them: _____

Have you been on the Marin County Adult Work Program before? Yes No.

What day(s) of the week are you available to work? _____

(You must work one consistent day a week, and you may work more than one day if available.)

Are you required to register as a sex offender? Yes No

If you are applying to AOWP from another county (courtesy case) you must provide contact information for your sending county at the time of your orientation.

I AM APPLYING FOR THE ADULT OFFENDER WORK PROGRAM, AND I UNDERSTAND THE FOLLOWING
(Please initial each line)

_____ A \$35 application fee is being assessed for the preparation of documents for my AOWP case. I understand that this is non-refundable.

_____ I understand that the AOWP staff will determine the number of days of work that I must perform to complete my sentence, based on the court order and custody credits that I have earned. Program fees are \$12 for each AOWP workday, to be paid prior to beginning my work assignment.

_____ I understand that I must meet in person with AOWP staff to go over the AOWP rules, timesheet preparation. for processing of paperwork for court, in order to be released from custody at the time of my court remand appearance or completion of any mandatory custody time.

_____ I understand that I must report any physical injuries, illnesses or limitations, that might affect my ability to do physical labor, and that I will be required to provide medical documentation as directed by AOWP staff.

_____ I agree to abide by the AOWP rules. (Read prior to signing — see additional form marked: AOWP Rules.)

FALSIFICATION OF THIS FORM MAY BE CAUSE TO REJECT YOUR APPLICATION.

I certify that the above information is true and complete.

Date: _____ Signature: _____