Request for Medical Care at DOC Host Facility

Today's Date: _____ County: _____

County Employee Contact Person: _____

Phone #: (_____) _____ Fax #: (_____) _____

Inmates Name: _____

Certified J & S Date: _____

Date of Birth: _____ Social Security Number: _____

DOC # (if known) _____

Describe physical injury or illness for which medical care is sought (attach any supporting documentation and list of medications prescribed): _____

_____

_____

_____

_____

_____

_____

DOC Facility Appointment Date and Time
(To be filled out by DOC)

Inmate to be seen by host facility: _____
(Facility Name)

Appointment Date: _____ Appointment Time: _____

County jail is responsible for transportation and security to medical appointments.

Signature: _____ Date: _____

❑ Prescription faxed to pharmacy vendor.

Inmate seen: _____ Signature: _____
(Date/Time)