

Escorted Leave Request Form

Facility: _____

Inmate Requesting Leave: _____
First Name MI Last Name DOC Number

Type of Leave Requested: Funeral Bedside Visit View Body at Funeral Home Only
 Marriage Medical

Address of Requested Visit: _____
Address City State

Type of Facility: Funeral Home Hospital Other (specify) _____

Contact Person: _____ *Title:* _____

Date/Time of Proposed Leave: _____ / _____ / _____ / _____ ()
(Month) (Day) (Year) (Time) Funeral Home/Hospital Phone Number

Person to be Seen: _____
First Name MI Last Name Relationship to Inmate

Request Review

(Provide specific detailed information for each question below)

Unit Manager/Case Manager IV/Correctional Security Manager I or II:

- Yes Is the inmate eligible for escorted leave? _____ Assigned custody level Staff Initials: _____
- No
- Yes Was this person's relationship to the inmate confirmed? (List documentation Staff Initials: _____
- No relied upon to establish relationship)
- Yes Has the inmate been granted a previous visit with the person? Staff Initials: _____
- No
- Yes Has the inmate been informed that he/she will not change clothes, go to a Staff Initials: _____
- No family residence, ride in a private vehicle and will be in restraints according to OP-040111, "Transportation of Inmates."
- Yes Have local law enforcement agencies been notified of the inmate's intended Staff Initials: _____
- No leave? (List agency contacted, provide name and rank of person notified, notification to a dispatcher is unacceptable)
- Yes Have hospital officials or funeral home officials been notified of the inmate's Staff Initials: _____
- No intended leave and that no other visitors may be present during the inmate's visit?

Comments: _____

Unit Manager/Case Manager IV/Captain

Date

Chaplain:

- Yes Was the type of facility and address confirmed? Staff Initials:_____
- No

- Yes Was the date and time of request confirmed? Staff Initials:_____
- No

- Yes Was the person the inmate wants to visit confirmed to be at this location? Staff Initials:_____
- No

- Yes If this is a hospital visit, will the doctor allow the inmate to visit? Staff Initials:_____
- No

Comments: _____

Chaplain Date

Deputy Warden/Assistant Facility Head: (Comments: Address whether reimbursement requirements are applicable and have been met)

- Recommend Approval: _____
- Recommend Deputy Warden/Assistant Facility Head/Supervisor/Captains Date
- Denial: _____

Warden/Facility Head: (Comments) _____

- Approved _____
- Denied Facility Head Date

- Approved _____
- Denied Regional Director Date

(If the inmate has ever been convicted of a violent or sex offense(s), the regional director must review).

Directions to location: _____

Date and time of departure: _____
(Date) (Time)

Date and estimated time of return to facility: _____
(Date) (Time)

Transportation Officers: _____

SPECIAL INSTRUCTIONS:

INMATES WILL NOT CHANGE CLOTHES OR RIDE IN A PRIVATE VEHICLE. THE INMATE WILL BE IN RESTRAINTS ACCORDING TO OP-040111, "TRANSPORTATION OF INMATES."

(R 11/18)