

**OKLAHOMA DEPARTMENT OF CORRECTIONS  
Health Care Leave Request Form**

Inmate Requesting Leave: \_\_\_\_\_ DOC Number: \_\_\_\_\_

First Name                      MI                      Last Name

Address of Appointment: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Type of Appointment:    Dental       Medical       Mental Health       Vision

Provider Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone Number : (\_\_\_\_) \_\_\_\_\_

Date of Proposed Appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Proposed Appointment: \_\_\_\_\_ AM / PM  
(Month)      (Day)      (Year)

Request Review: (Comments, Notes and Pertinent Information)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Unit Manager/Case Manager IV/Captain**

Yes  No Is the inmate eligible for escorted leave per OP-031001?  
Custody Level: \_\_\_\_\_ Assigned Staff Signature: \_\_\_\_\_

Yes  No Does the inmate require an escort? If inmate requires an escort, provide name and contact Information  
Escort Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Yes  No Did the Inmate sign the "Affidavit of Financial Responsibility" (DOC 140121D)

Comments \_\_\_\_\_

Unit Manager's /Case Manager IV/Captain Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Health Service Administrator or Designee (for minimum security and higher only)**

Yes  No Did the inmate meet with his/her ODOC provider and complete a "Waiver of Treatment?"  
Date "Waiver of Treatment completed: \_\_\_\_\_ Staff Signature: \_\_\_\_\_

**Deputy Warden/Assistant District Supervisor**

Comments: \_\_\_\_\_

Recommend Approval       Recommend Denial

Deputy Warden/Assistant District Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Warden/ District Supervisor**

Comments: \_\_\_\_\_

Approved  Denied Warden/ District Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Approved  Denied Division Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Approved  Denied Safety Administrator: \_\_\_\_\_ Date: \_\_\_\_\_

**(If inmate has ever been convicted of violent or sex offense(s), the division manager must review)**

Direction to Location: \_\_\_\_\_

Date of Departure: \_\_\_\_\_ Time of Departure: \_\_\_\_\_

Date of Estimated Return to Facility: \_\_\_\_\_ Time of Estimated Return to Facility: \_\_\_\_\_

Transportation Orders: \_\_\_\_\_

Special Instructions:

**INMATES WILL NOT CHANGE CLOTHES OR RIDE IN A PRIVATE VEHICLE. THE INMATE, WITH THE EXCEPTION OF PREGNANT INMATES, WILL BE IN FULL RESTRAINTS AT ALL TIMES (MAY NOT APPLY FOR COMMUNITY CORRECTIONS INMATES).**