

OKLAHOMA DEPARTMENT OF CORRECTIONS

Correctional Center/Facility

Involuntary Medication Hearing - Staff Representative Fact Sheet

Facility Inmate Name Inmate Number

1. [] Appointed as staff representative by the Medication Review Committee Chair:

Staff Name Printed Date Facility

2. [] Familiarized self with inmate's mental health history and current psychiatric documentation for involuntary medication.

3. [] Met with inmate on

- A. [] Explained inmate's rights prior to involuntary medication hearing.
B. [] Offered assistance in preparing case objecting to involuntary medication.
C. [] Explained nature and purpose of the hearing.

4. [] The following individuals were notified to appear at the hearing scheduled for:

Date at Time a.m./p.m., at Location

to object to administration of involuntary medication(s):

Name Date/Time of Notification Form of Notice

5. [] At the hearing that took place on (Date), the following witnesses objecting to involuntary medication were present:

[]

The following witnesses supporting involuntary medication were cross-examined:

[]

6. [] If the Medication Review Committee decision supports administration of involuntary medication and the inmate appealed the decision, I was involved in this appeal.

Staff Representative Date

cc: Medical File Chair