

OKLAHOMA DEPARTMENT OF CORRECTIONS

Correctional Center

Involuntary Medication Appeal Request

DATE: _____

THRU: _____, Warden and

TO: _____, Medication Review Committee Chairperson

FROM: _____
Inmate Name Inmate Number

In response to a Medication Review Committee decision, given on _____
Date

authorizing the administration of involuntary medication(s) at _____
Unit

Inmate _____ requests to appeal this
Name

decision in accordance with his/her due process rights.

Inmate's Signature

Witness's Name Printed

Date

Witness's Signature

REVIEWED BY:

_____, warden, on _____ and
Printed Name Date

delivered to _____, physician.

Warden's Signature

cc: Medical File