OKLAHOMA DEPARTMENT OF CORRECTIONS
FOOD SERVICES WORK PERMISSION SLIP

Inmate Name _____ ODOC Number _____

TO: _____

FACILITY: _____

FROM: Medical Services unit

The above named inmate has been medically evaluated and approved to work in the kitchen:

☐ **YES** ☐ **NO**

Signature of health care provider/RN/LPN _____ Date _____

Original: Medical Record
Copy: Food Services

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