

# Request For Medical Care at DOC Host Facility

Today's Date: \_\_\_\_\_ County: \_\_\_\_\_

County Employee Contact Person: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

Offender Name: \_\_\_\_\_

Certified J and S Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

DOC # (if known) \_\_\_\_\_

Describe physical injury or illness for which medical care is sought (attach any supporting documentation and list medications prescribed):

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## DOC Facility Appointment Date and Time

(To be filled out by DOC)

Offender to be seen by host facility \_\_\_\_\_  
(Facility Name)

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

County jail is responsible for transportation and security to medical appointments

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Offender seen: \_\_\_\_\_  
Date & Time