OFFENDER-PAID DURABLE MEDICAL EQUIPMENT (DME)

NAME	DOC NUMBER	DATE
FACILITY	BED NUMBER	

I request the self-paid DME item below be approved and my Record of Property updated:

DME DESCRIPTION	**FROM** (Vendor Name/Address **and** method of shipping)	**RECEIVED** **PROPERTY ROOM USE ONLY**

SIGNATURE OF INDIVIDUAL	**Patient:** **Send to Health Services Manager/Health Authority/ designee for approval**

APPROVALS

☐ The above DME meets the guideline requirements for self-paid DME. ☐ Denied

HEALTH SERVICES MANAGER/HEALTH AUTHORITY/DESIGNEE SIGNATURE	DATE
FACILITY MEDICAL DIRECTOR/CLINICAL LEAD SIGNATURE	DATE

☐ The above DME meets the guideline requirements for self-paid DME. ☐ Denied

Comments: ____________________

SUPERINTENDENT/DESIGNEE SIGNATURE	DATE

Distribution: Original – Property Sergeant Copy – Individual

PROPERTY ROOM

☐ DME item described above was received

Item inspected: ☐ Suitable for prison environment ☐ Not suitable for prison environment

☐ Individual notified

☐ Individual acknowledges receipt of above item: ____________________ ____________

SIGNATURE OF INDIVIDUAL DATE

☐ Item added to DOC 05-062 Offender Property

PROPERTY ROOM SERGEANT/DESIGNEE SIGNATURE	DATE

Distribution: Original – Health Record Copies – Property Room, Unit File, Individual

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.