Department of Corrections
WASHINGTON STATE

PATIENT-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 PATIENT	**Patient: Send to Health Services Manager/designee for approval**

APPROVALS

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

HEALTH SERVICES MANAGER/DESIGNEE SIGNATURE	DATE

FACILITY MEDICAL DIRECTOR/CLINICAL LEAD SIGNATURE	DATE

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

Comments: _____

CAPTAIN/MI2 LT/DESIGNEE SIGNATURE	DATE

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

Comments: _____

SUPERINTENDENT/DESIGNEE SIGNATURE	DATE

Distribution: Original – Property Sergeant Copy – Patient

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NAME	DOC NUMBER	DATE

PROPERTY ROOM

☐ DME item described above was received

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

☐ Patient notified

☐ Patient acknowledges receipt of above item: _____ _____

SIGNATURE OF PATIENT DATE

☐ Item added to electronic property record

PROPERTY ROOM SERGEANT/DESIGNEE SIGNATURE	DATE

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