MEDICAL PAROLE APPLICATION

(to be completed by requesting party)

Note: **Applications sent to locations other than the supervising P&P officer will be considered invalid.**

Date of Request: _____

Requestor: _____ Relationship: _____

Offender Name: _____ Offender Number: _____

Date of Birth: _____ Age: _____

Parole Eligibility Date: _____ Discharge Date: _____

Prior Parole Appearances: _____

Medical:	Yes ☐	No ☐	Date(s): _____
Non-Medical:	Yes ☐	No ☐	Date(s): _____

Offense(s): _____

To be completed by the requestor (per DOC Policy 4.6.7):

Be as specific as possible.

Reasons for the requested medical parole:

_____
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Name, address, and telephone number of proposed caretaker/facility that has agreed to provide care to the parole candidate. Where will the candidate live?

Name, address, and telephone number of the physician who has agreed to provide medical care to the parole candidate during the medical parole:

What are the specific travel arrangements for transporting the parole candidate to the caretaker /facility. How will the candidate get to the doctor?

Provide a statement documenting the parole candidate's ability to pay for ongoing medical and/or residential care. By what means will the candidate pay for medical care?

Provide a statement of the requesting party's willingness to cooperate with the Board of Pardons and Parole and the Department of Corrections in all matters relating to the status of the parole candidate: