



## Bereavement Visit Request - Institutions

### Part I: Complete for all Bereavement Visits

Facility: _____	Date: _____	Private Visitation <input type="checkbox"/>	Deathbed Visit <input type="checkbox"/>	Video Visit <input type="checkbox"/>
Offender Name: _____		Number: _____		
Offense(s): _____				
Total Sentence: _____		PED: _____	MPRD: _____	GTRD: _____
DRC: _____	DRCI: _____	Security Level: _____	Date Assigned Security Level: _____	
Date of Birth: _____	Class Level: _____	Medical Class: _____	Mental Health Class: _____	
Detainers: _____				
Dates of Prior Private Visitation/Deathbed Visits: _____				
Name of Deceased/Ill Relative: _____			Relationship to Offender: _____	
Date of Proposed Visit: _____		Time of Visit: _____		

Are there any unusual circumstances concerning this private visitation/deathbed visit? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Explain: _____	
Will any other offenders request to attend? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are they approved? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Are they disapproved? Yes <input type="checkbox"/> No <input type="checkbox"/>
Names of other offenders and facility assignment: _____	

Family Member Contacted: _____		Relationship to Offender: _____	
Phone: _____	Will Any Family Members Object? Yes <input type="checkbox"/> No <input type="checkbox"/>	Explain: _____	
Are Funds Available to Cover Expenses? (If applicable) Yes <input type="checkbox"/> No <input type="checkbox"/>		Who Will Pay Expenses: _____	
How Will Payment be Made? _____			

Name/Title of Staff Member Verifying All Information: _____	
Recommendation: _____	Date: _____

Facility Unit Head Recommendation: (Or Administrative Duty Officer) Approved <input type="checkbox"/> Disapproved <input type="checkbox"/> Date: _____	
Comments: _____	
Signature: _____	



**Part II: Complete for Bereavement Visit Attendance**

**Private Visitation Information:** Cause and Date of Death: \_\_\_\_\_

Location of Private Visitation: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_

Name of Funeral Home Handling Arrangements: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**Deathbed Information:** Nature of Illness or Injury: \_\_\_\_\_

Physician's Prognosis: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Location of Proposed Visit: \_\_\_\_\_

Address: \_\_\_\_\_

Does Physician or Hospital Authority Have Any Objection to Proposed Visit: Yes  No

Hospital Authority Contacted: \_\_\_\_\_ Phone: \_\_\_\_\_

**Local Law Enforcement Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_

Specify Objections (if any): \_\_\_\_\_

**Probation/Parole Official Contacted:** \_\_\_\_\_ Phone: \_\_\_\_\_

Specify Objections (if any): \_\_\_\_\_

<b>Expenses:</b> \$ _____ Mileage	Est. Mileage: _____	<input checked="" type="checkbox"/> State Mileage Rate	_____
\$ _____ Salary	Est. Hours: _____	<input checked="" type="checkbox"/> Hourly Rate	_____ <input checked="" type="checkbox"/> Number of Officers _____
\$ _____ Other	Specify: _____		
\$ _____	<b>TOTAL EXPENSES</b>		

**Regional Administrator's Decision:** Approved  Disapproved  Date: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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