



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): _____

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

Regional Administrator's Decision: Approved ☐ Disapproved ☐ Date: _____

Comments: _____

Signature: _____