



**OREGON STATE HOSPITAL
Visitor Application**

Instructions: Please fill out this application completely as it applies to you. **PLEASE PRINT OR TYPE!** Incomplete or illegible applications may cause a delay in processing times and application may be returned or denied.

Patient Name: _____

Unit: _____

Adult **Spiritual/Pastoral**

Visitor Name: _____ Phone: _____ Male Female

Mailing Address: _____ City _____ State _____ Zip Code: _____

Height: _____ Weight: _____ Hair color: _____ Eye Color: _____

Date of Birth: ____/____/____ Soc. Security No: _____-_____-_____

How would you like to be notified? Phone Mail Email: _____

1. What is your relationship with the patient? _____
2. Are you a current or past OSH employee? Yes No If yes, when? _____
3. How long have you known this patient? _____
4. Are you visiting anyone else in a correctional facility or public psychiatric facility?
 Yes No If yes, whom? _____ Where? _____
5. Have you been arrested within the last 2 years? Yes No

Failure to disclose arrest history will result in denial of this visiting application. I understand that by applying for visitation, I give permission to have a confidential LAW ENFORCEMENT DATA SYSTEMS (LEDS) check performed. (NOTE: There is no LEDS check for persons under the age of 18 years.)

Printed Name of Applicant

Signature of Applicant

Date

For Official Use Only

Received by: _____ Received Time: _____ Date: _____

LEDS Operator: _____ Complete date: _____

Complete Time: _____ Result: _____



Patient Name: _____	Unit: _____
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Minor	
Name: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	
Mailing Address: _____ City _____ State _____ Zip Code: _____	
Date of Birth: _____	
Parent or Guardian	
Name: _____ Relationship: _____	
Mailing Address: _____ City _____ State _____ Zip Code: _____	
Phone: _____	
How would you like to be notified? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email: _____	

PARENT/LEGAL GUARDIAN PERMISSION FOR CHILD'S VISIT	
<i>(Note: Every Applicant including minors must complete and submit a separate application)</i>	
The Forensic Services policy requires that all non-emancipated persons under the age of 18 must have the approval of their legal guardian or the custodial parent, and must be accompanied during the visit by an adult also approved to visit the same patient.	
I hereby give my permission for (MINOR) to visit with the patient named above, who is receiving treatment in a secure forensic treatment environment at the Oregon State Hospital. I do so with the understanding that neither the Forensic Services and the Oregon State Hospital nor any of its representatives, shall be or become liable or responsible for any loss injury, or damage to persons or property, resulting directly or indirectly from any act.	
_____ Printed Name of Parent/Legal Guardian of Minor	_____ Date
_____ Signature of Parent/Legal Guardian of Minor	_____ Date

Office Use Only			
Rec'd by: _____	Date: _____	Sent to: _____	Program: _____