Walk-thru Metal Detector Medical Exception Form

To be completed by visitor/volunteer/contractor:

Visitor/Volunteer/Contractor Name: ____________________________________________________________________________________________
(Please Print Legibly) First Name   M.I.    Last Name
__________________________________________________________________________________________________________________________
Address       City    State   Zip Code
__________________________________________________________________________________________________________________________
Phone Number    E-Mail Address

Specify your section (volunteer), your company (contractor), or the name and SID# of the inmate you will visit (visitor):

Section: ___________________________________________________ Company: _______________________________________________________

Inmate Name: _______________________________________________________________ SID#: __________________________________________

I hereby release _____________________________________________________________________________________________________________
Doctor’s Name     Medical Facility     Phone Number
to provide verification of the medical condition(s) listed below to the Oregon Department of Corrections.

Visitor/Volunteer/Contractor Signature      Date
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To be completed by physician:

Affected area(s) that contain metal products that may trigger reaction from the metal detector. Please check all that apply:

___Right Forearm       ___Left Forearm       ___Right Hip       ___Left Hip       ___Neck
___Right Bicep         ___Left Bicep         ___Right Calf      ___Left Calf      ___Head
___Right Elbow         ___Left Elbow         ___Right Thigh     ___Left Thigh     ___Spinal Column
___Right Wrist         ___Left Wrist         ___Right Knee     ___Left Knee     ___Other: ________
___Right Hand         ___Left Hand          ___Right Foot      ___Left Foot
___Right Hand Finger(s) ___Left Hand Finger(s)  ___Upper Torso    ___Lower Torso
___Right Shoulder     ___Left Shoulder      ___Right Ankle     ___Left Ankle

Other medical condition(s) that may prevent visitor/volunteer/contractor from being processed through the metal detector:

___Pacemaker         ___Metal Braces       ___Wheelchair (please note if able to stand)

Comments: ________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________

Physician Signature ___________________________________________ Date ___________________________ Phone Number ________________________

This is a general form for all DOC facilities. Contact your facility to submit the completed form.