OKLAHOMA DEPARTMENT OF CORRECTIONS
AUTHORIZATION TO APPLY
RESTRAINTS to a PREGNANT INMATE

Date: _____ Time: _____

Authorization is requested to place restraints on _____
Inmate Name and ODOC Number

Purpose of Restraints: _____External Transport _____Internal Facility Escort

Expected date and time of restraints: _____from _____am/pm to _____am/pm

Restraints Requested: _____ Handcuffs (front only) _____ Belly Chain _____ California Cuffs

Restraints are needed for the following reason(s): _____To prevent self-injury _____ Documented escape risk

_____To prevent injury to others _____To prevent injury to unborn child

Please describe recent documented specific behavior(s) which support the reason(s) checked above:

_____

_____

_____

_____

Requested by: _____
Chief of Security or Deputy Warden

Authorization to place inmate in restraints is granted. Yes _____ No _____

Restraints approved: _____ Handcuffs (front only) _____ Belly Chains _____ California Cuffs

Authorization expires at: _____

_____ _____
Medical Staff Date/Time Facility Head (or designee) Date/Time

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Post Application of Restraints

Restraints removed by:_____
Name/Title

at_____
Date/Time

Medical assessment conducted by: _____
Name/Title

on_____
Date/Time

Original: Facility Head
Copy: Inmate Medical Record