DEPARTMENT OF CORRECTIONS
MULTIPLE INMATE REQUEST FOR DISBURSEMENT

PAYEE: _____

NAME

_____

STREET ADDRESS

_____

CITY, STATE & ZIP

Name (Printed)	ODOC #	Name (Signature)	Amount	Date

INMATE REQUEST APPROVED BY:_____   _____

Staff   Signature   Date

_____ _____   _____ _____

Trust Fund Officer Signature   Date   Cashier   Signature   Date

If check is to
be returned
to the facility   _____

Print Department, Position, or Name check is to be returned to

This disbursement may only be used if more than five inmates are participating. Number of pages attached_____

DOC 120230C
(R 11/21)