OKLAHOMA DEPARTMENT OF CORRECTIONS

Correctional Center

Involuntary Medication Appeal Request

DATE:			
THRU:	, Facility Head and		
TO:	, Medication Review Committee Chairperson		
FROM:			
Inmate Name	ODO	OC Number	
In response to a Medication Review	v Committee decision, given on		
		Date	
authorizing the administration of inv	oluntary medication(s) at	 Unit	
Inmate	requests t		
	Name	o appear tino	
decision in accordance with his/her	due process rights.		
Inmate's Signature	Witness's Nam	Witness's Name Printed	
Date	Witness's Sig	Witness's Signature	
REVIEWED BY:			
	, facility head, on	and	
Printed Name delivered to	, psyc, psyc,	chiatric provider.	
Facility Head's Signat	ure		

cc: Medical File