

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:

- | | | | | |
|---|--|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Right Forearm | <input type="checkbox"/> Left Forearm | <input type="checkbox"/> Right Hip | <input type="checkbox"/> Left Hip | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Right Bicep | <input type="checkbox"/> Left Bicep | <input type="checkbox"/> Right Calf | <input type="checkbox"/> Left Calf | <input type="checkbox"/> Head |
| <input type="checkbox"/> Right Elbow | <input type="checkbox"/> Left Elbow | <input type="checkbox"/> Right Thigh | <input type="checkbox"/> Left Thigh | <input type="checkbox"/> Spinal Column |
| <input type="checkbox"/> Right Wrist | <input type="checkbox"/> Left Wrist | <input type="checkbox"/> Right Knee | <input type="checkbox"/> Left Knee | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Right Hand | <input type="checkbox"/> Left Hand | <input type="checkbox"/> Right Foot | <input type="checkbox"/> Left Foot | |
| <input type="checkbox"/> Right Hand Finger(s) | <input type="checkbox"/> Left Hand Finger(s) | <input type="checkbox"/> Upper Torso | <input type="checkbox"/> Lower Torso | |
| <input type="checkbox"/> Right Shoulder | <input type="checkbox"/> Left Shoulder | <input type="checkbox"/> Right Ankle | <input type="checkbox"/> 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.