PASS REQUEST FORM

Submit By Email

(BOARD APPROVAL IS REQUIRED FOR PASS)

PLEASE SEND COMPLETED FORM VIA FAX OR EMAIL: (503) 229-0215 or psrb@oregon.gov

Form should be completed and submitted by the Case Manager

Date Submitted:_____ Client Name: _____

Client has been on CR ◯ months ◯ years and has been living at an Choose One: for ◯ months ◯ years.

Date/Time Leaving: Date/Time Returning:

Address of Destination: _____

Purpose of the Pass:

_____

Plan for traveling to destination:

_____

Client has previously taken this pass of times and last took this pass on Date: or N/A: ☐

Briefly describe any concerns/issues with previous or similar passes:

_____

Who are the Host(s) for this pass? ☐ N/A or Name(s)_____

Have you verified the CURRENT pass with the Host(s)? Yes, Date: _____ Are Host(s) aware of conditions? Choose One:

Case manager has a contact number(s) to reach client while on pass: Yes ☐ No ☐ (explain) _____

Describe monitoring and supervision plan while client is on this pass (Required if pass is overnight):

_____

Does current CR Order require the client be supervised outside the facility? ☐ Yes(Board approval required) ☐ No

If no, does the client have pass privileges that allow for this pass? Yes ☐ No ☐ (Board approval required)

VICTIM(S)

Do victim(s) live or did instant offense occur near pass destination?

Yes ☐ (if yes, please address in monitoring/supervision plan) No ☐

Has victim advocate been notified: Yes, by CM ☐ No, PSRB needs to notify ☐ Not Required ☐

Clients with sex offense history:

Are past victim(s) minors? Yes ☐ No ☐

Will minors be present at or near pass destination?

Yes ☐ (if yes, please address in monitoring/supervision plan) No ☐

Does current CR Order restrict contact with minors? Yes ☐ (Board approval required) No ☐

Case Manager Name:_____ has been client's case manager for Phone #:_____

Are all monthly reports up to date? Yes ☐ No ☐ (if no, please submit past due monthly reports)

Has client had a recent psychotropic medication change?

No ☐ Yes ☐ (if yes, please address in monitoring/supervision plan if overnight)

Is the client able to self-administer his/her medication?

No ☐ Yes ☐ (if no, please address in monitoring/supervision plan if overnight)

Is client currently meeting his/her conditions of release? Yes ☐ No ☐

Does case manager/treatment team approve this pass? Yes ☐ No ☐

Office Use Only

_____APPROVED

_____DENIED

Yes or No - Waiver received?

Reset Form

Revised 8/30/19