Ocean County Department of Corrections
Medical/Dental Request
Correctional Facility

PLEASE PRINT

Inmate Name: _____ ID Number: _____ Housing Unit _____

Check Off Request: ❑ Medical ❑ Dental ❑ Mental Health
Chief Complaint: _____

_____

1. I understand that my requesting health services may result in having my account charged for health care service rendered.
2. I understand that I may be assessed a $5.00 (five dollar) fee for any visit to health care staff.
3. I understand that I will be charged a $1.00 (one dollar) co-payment for each medication I receive.
4. If I disagree any charges assessed, I understand that I may file a grievance to the Chief of Support Services.

Inmate Signature: _____ Date: _____

Response/Recommendation
(To be completed by Medical Staff Only)

❑ **MEDICAL** ❑ Sick call ❑ Nurse ❑ Doctor ❑ Dentist ❑ Eye Doctor $ _____

❑ **NO CHARGE** Reason: _____

❑ **MEDICATION** _____ X $1.00 = $ _____

❑ **OTHER-DESCRIPTION** _____ – $ _____

❑ **OTHER** _____ $ _____

TOTAL $ _____

Comments: _____

_____

I certify that the above services were rendered:

Printed name and/or stamp: _____

SIGNATURE: _____ DATE: _____