MEDICAL SUMMARY OF FEDERAL PRISONER/ ALIEN IN TRANSIT
U.S. Department of Justice

TB Clearance ❑ Yes ❑ No

1) PPD Completed: _____ Date

Results: _____

2) CXR Completed: _____ Date

3) Health Authority Clearance: _____

_____

Sign Date

Note:
Dates listed above must be within one year of this transfer.

I. PRISONER/ALIEN

Name: _____ Prisoner/Alien Reg. # _____ D.O.B: _____

Departed From: _____ Date Departed: _____

Destination: _____ Reason for Transfer: _____

Dist. Name: _____ Dist. # _____ Date in Custody: _____

II. Current Medical Problems

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

			Medication Required For Care En Route	
Medication	**Dose**	**Route**	**Instructions For Use** (Include proper time for Administering)	**Stop**

Additional Comments:

III. SPECIAL NEEDS AFFECTING TRANSPORTATION

Is prisoner medically able to travel by BUS, VAN or CAR? ❑ Yes ❑ No If no, Why not?

Is prisoner medically able to travel by airplane? ❑ Yes ❑ No If no, Why not?

Is prisoner medically able to stay overnight at another facility en route to destination? ❑ Yes ❑ No If no, Why not?

Is there any medical reason for restricting the length of time prisoner can be in travel status? ❑ Yes ❑ No If yes, state reason:

Does prisoner require any medical equipment while in transport status? ❑ Yes ❑ No If yes, What equipment?

Sign & Print Name- Certifying Health Authority: _____ Phone Number: _____ Date Signed: _____