

Minnesota Department of Corrections
Delegation Authorization

MCF- _____

Date: _____

Type of Delegation: Medical Court Other _____
 Deathbed/Funeral/Wake (attach narrative if required by warden)

Last Name First Name MI OID Custody Level Living Assignment

Appointment Date/Time: _____

Destination (name, address, phone): _____

Depart Date/Time: _____ Return Date/Time: _____

Date/Time of Transfer to Another Agency: _____ Agency Name: _____

Staff originating Request: _____

Reason for Request: _____

Certified Court Order Verified: _____

Name/Signature of Verifier: _____

Security/Medical Concerns and Special Instructions: _____

Office of Special Investigations (OSI):
 All applicable information provided No information available

Law Enforcement contacted, name/phone of person contacted: _____

Approved Disapproved

Captain/Designee

For Deathbed/Funeral/Wake or Private Medical Delegation only
 Approved Disapproved

Warden/Designee

Offender Search Conducted by: _____

Departure (printed & signature) Return (printed & signature)

Restraints

Applied by (printed & signature) Removed by (printed & signature)

Property: _____
Staff securing property Location of property

Transporting staff: _____ Car assignment: _____

Distribution (check all that apply and make appropriate number of copies)
 Base File Transport Officer(s) Control Center Case Manager
 Watch Commander Intake Count Officer Truck Gate
 Incarcerated Person Control Officer Health Services Financial Services