MN DEPARTMENT OF CORRECTIONS – **HEARINGS AND RELEASE UNIT**

1450 Energy Park Drive, Suite 200 ◊ St. Paul, MN 55108-5219

WAIVER OF HEARING

INDIVIDUAL'S NAME: _____ **OID:** _____

____ By initialing this line, I admit the violation(s) alleged in the Notice of Violation and accept the disposition recommended by the agent in the violation report. **A disposition is not final until approved by a hearing officer.**

____ By initialing this line, I understand that there is a 90-day cap on reincarceration for first-time release violators who are not serving sentences for sex offenses (Minn. Stat. § 244.30). I also understand that the 90-day cap does not apply if a hearing officer finds substantial and compelling reasons to believe that a longer incarceration period is necessary to protect the public.

____ By initialing this line, I understand my agent has recommended more than 180 days and this disposition includes a determination of ongoing risk to the public or unamenability to supervision per Minn. Rule, 2940.3800, subp. D.

I UNDERSTAND THE DISPOSITION INCLUDES THE FOLLOWING:

☐ Revocation of my release on sentence number _____ and continue to the Confinement Release Date (CRD) of the new commitment sentence on sentence number ____, CRD _____.

☐ Revocation of my release on current sentence, sentence number _____, to expiration of sentence, or conditional release sentence expiration if applicable. This expiration date (maximum confinement or termination milestone) is determined to be _____ and is subject to audit by the Minnesota Department of Corrections (MN DOC).

☐ Revocation of my release and return to incarceration for _____ days, I will receive credit from the date of my arrest or availability to the MN DOC, which is determined to be_____ and is subject to audit by the MN DOC.

☐ Completion of an institution-based treatment program if determined eligible. This disposition includes a revocation period of 365 days or less from the date of my arrest or availability to the MN DOC, which is determined to be_____ and is subject to audit by the MN DOC. I understand that completion of programming may exceed 365 days and result in an extension of my imprisonment at a future review hearing. I accept the agent's recommendation to complete the following program(s):

- ☐ substance use disorder programming
- ☐ sex offense programming

☐ Revocation of my status in the Challenge Incarceration Program (CIP). I understand that I will be returned to institution status to serve my original term of imprisonment as calculated by the sentence administration unit (SAU) and I will receive credit from the date of my arrest or availability to the MN DOC, which is determined to be _____ and is subject to audit by the MN DOC..

____ By initialing this line, I understand I may be subject to further consequences because of my return to incarceration status. This may include extension of my confinement release date for discipline reasons, treatment completion/failure, ECRC review, or lack of an approved release plan.

INDIVIDUAL'S (RELEASEE) SIGNATURE_____ DATE:_____

WITNESS SIGNATURE _____ DATE:_____

HEARING OFFICER REVIEW:

☐ APPROVED ☐ PROCEED TO HEARING

☐ COMPELLING AND SUBSTANTIAL REASONS FOUND TO EXCEED THE 90-DAY CAP ☐ APPLY THE 90-DAY CAP

HEARING OFFICER SIGNATURE _____ DATE:_____

HEARING OFFICER PRINTED NAME: