OC/Chemical Agents Medical Contraindications Form

Institution:_____ **UOF #:**_____
Inmate Name:_____ **Commitment #:**_____

The following is to be completed by the Medical Provider prior to a planned use of force. **All questions MUST be answered with a "√."** Answering **"Yes"** to any of the following may constitute a contraindication for the use of OC and/or Chemical Agents:

Yes___ No___ Does the inmate have Asthma?

Yes___ No___ Does the inmate have Cardio Obstructive Pulmonary Disease (COPD)?

Yes___ No___ Does the inmate have current acute respiratory infection (e.g. bronchitis, pneumonia)?

Yes___ No___ Does the inmate have significant heart disease manifested by frequent angina?

Yes___ No___ Does the inmate have recent Myocardial Infarction?

Yes___ No___ Does the inmate have a recent hospitalization/medical condition that would preclude the use of OC and/or Chemical Agent?

Yes___ No___ Does the inmate have open skin lesions/burns?

Yes___ No___ Other, please specify:_____

Yes___ No___ Are there contraindications for the use of OC and/or Chemical Agents? If **"No,"** and any line above has been answered **"Yes,"** please explain:

_____

_____

Qualified Healthcare Professional Completing Form Name (PRINT) (If MD/NP/PA, Leave Blank**)**

Reviewing Qualified Healthcare Professional's Name (MD/NP/PA) (PRINT)

Qualified Healthcare Professional Signature (MD/NP/PA) **Date** **Time**

This form may be completed electronically where able via the Department's approved medical documentation system

	Massachusetts Department of Correction Director of Operational Services **USE OF FORCE REVIEW EXTENSION REQUEST**	In accordance with: 103 CMR 505, *Use of Force*

USE OF FORCE PACKAGE REVIEW EXTENSION REQUEST
(Attachment #2 to 103 CMR 505, *Use of Force*)
Dates reflect "business days" in accordance with 103 CMR 505, *Use of Force*
(To be completed electronically in PowerDMS)

UOF #:UOF # Here

Inmate's Name: Name Here **Commitment #:**Comm. # Here

Check ONE: ☐ Initial Extension Request ☐ Subsequent Extension Request (# _____ request)

Original Incident Date: Click to enter a date.

Date Received by Director of Operational Services: Click to enter a date.

Length of Extension Request:_____

New Due Date: Click to enter a date.

Reason for Extension Request: Click or tap here to enter text.

Signed Electronically by the Director of Operational Services in PowerDMS.

Deputy Commissioner, Prison Division

Check ONE: ☐ Approved ☐ Denied (Explain Below)

Comments: Click or tap here to enter text.

Signed Electronically by the Deputy Commissioner of the Prison Division in PowerDMS.

	Massachusetts Department of Correction Director of Operational Services **USE OF FORCE REVIEW INCOMPLETE REPORT NOTICE**	In accordance with: 103 CMR 505, *Use of Force*

USE OF FORCE INCOMPLETE REPORT NOTICE
(Attachment #3 to 103 CMR 505, *Use of Force*)
Dates reflect "business days" in accordance with 103 CMR 505, *Use of Force*

TO: Insert Name

THRU: Insert Name, Superintendent, Insert Institution

FROM: Insert Name, Director, Operational Services Division

DATE: Insert Date

RE: **Request for Additional Information in Your Incomplete Use of Force Report**

Following a Use of Force (UOF #Here) incident on Insert Date in which you were involved, you submitted a written report (IR #Here) of said incident pursuant to 103 CMR 505.18(1). 103 CMR 505.18(1) identifies the information that must be contained in such a report. Following my review of your written report, I have determined that your report does not contain the required information necessary to conduct a substantive review pursuant to 103 CMR 505.19(4). Therefore, please provide the following additional information, specifically: Identify Information Lacking in Report.

Please provide the required information within ten (10) business days of this memorandum.

If you choose not to submit the required information by the specified deadline, your decision will be noted in the use of force package documentation. Please be advised that if the Special Operations Division is unable to conduct a complete evaluation of the use of force incident, the matter may be referred to the Use of Force Joint Triage Committee (JTC) for further review and the Professional Standards Unit (PSU) for further investigation.

Received in hand by:_____
Signature

Served in hand by:_____ **Date:**_____ **Time:**_____
Print Name

Served in hand by:_____
Signature

****Please attach completed Attachment #3 to the corresponding Use of Force Package(s)****