TRANSCOR AMERICA, LLC

PRISONER TRANSPORT ORDER FORM
FAX ORDERS: 615.251.6855 OR 1.800.211.9438

CUSTOMER INFORMATION

CUSTOMER NAME ______________________ ASSIGNOR NAME ______________________

PHONE NUMBER ______________________ PURCHASE ORDER # ______________________

PRISONER INFORMATION

NAME: ____

(LAST) (FIRST) (MIDDLE)

S.S. # ______________________ A/KA/ ______________________

D.O.B. ______________________ SEX ____________ RACE ____________ BOOKING # ____________

HEIGHT __________ WEIGHT __________ HAIR COLOR __________ EYE COLOR __________ INMATE # ____________

TYPE OF MOVE

___BENCH WARRANT ___COMMITMENT ORDER ___COURT DATE ___FORM VI ___GOVERNOR'S WARRANT

___IN-STATE ___INTERSTATE COMPACT ___WRIT ___JUDGEMENT ORDER

___RELEASE DATE ___PRE-SIGNED WAIVER ___WAIVER

PICKUP ON DATE____________ COURT DATE____________ DEADLINE (P/U DATE) ____________ DEADLINE (D/O DATE)____________

AGENT TO APPEAR IN COURT? YES___ NO___

PAPERWORK REQUIRED? YES___NO___ PICKUP WITH ORGINAL PAPERWORK? YES___NO___

CHARGES & CRIMINAL HISTORY

CURRENT CHARGE(S): ____

CRIMINAL HISTORY: ____

HISTORY OF ASSAULT? YES____ NO____ HISTORY OF ACTUAL OR ATTEMPTED ESCAPE? YES____NO____

MEDICAL INFORMATION (CHECK ALL THAT APPLY) (MUST BE COMPLETED BEFORE ORDER IS ACCEPTED)

PRESENT/PAST MEDICAL CONDITIONS THAT MAY EFFECT TRANSPORT --- **INDICATE ALL THAT APPLY:**

DIABETES_________ HEPATITIS _____ (IF YES, TYPE)____ HYPERTENSION _______MENTAL ILLNESS _______SUICIDAL _________SEIZURE_____________

PREGNANT ________________IF YES, # OF WEEKS ______________________ ANY COMPLICATIONS? ______________________

SURGERY WITHIN PAST NINETY DAYS ________TYPE ______________________ANY COMPLICATIONS______________________

IS PRISONER HOUSED IN GENERAL POPULATION ______________INFIRMARY ______________SECLUSION ______________OTHER ______________

OPEN WOUNDS ______________________DO WOUNDS REQUIRE DRESSINGS______________________

MEDICAL EQUIPMENT & MEDICATION (CHECK ALL THAT APPLY) (MUST BE COMPLETED BEFORE ORDER IS ACCEPTED)

CANE ____________WALKER __________WHEELCHAIR __________CASTS /SLINGS (IF YES, WHICH LIMB)___________COLOSTOMY ___________CATHETER__________

PRESCRIPTION MEDICATIONS / SPECIFY ____

____

A 10-DAY SUPPLY OF BOTH OVER-THE-COUNTER AND PRESCRIPTION MEDICATIONS MUST BE PROVIDED. IF NECESSARY, A PRESCRIPTION FOR A 10-DAY SUPPLY WILL BE ACCEPTED.

HOLDING AGENCY INFORMATION

AGENCY NAME______________________ CONTACT PERSON ______________________

ADDRESS______________________ CITY ______________________ STATE ______________

PHONE NO. ______________ 24-HOUR PHONE NO. ______________ FAX NO. ______________ HOURS ______________

SPECIAL INSTRUCTIONS OR RESTRICTIONS ____

DESTINATION AGENCY

AGENCY NAME ______________________ CONTACT PERSON ______________________

ADDRESS ______________________ CITY ______________________ STATE ____________

PHONE NO. ______________ 24-HOUR PHONE NO. ______________ FAX NO. ______________ HOURS ______________

SPECIAL INSTRUCTIONS OR RESTRICTIONS ____

UPON PLACING THIS ORDER, YOU AGREE THAT TRANSCOR WILL NOT BE LIABLE FOR MEDICAL COSTS ASSOCIATED WITH NON-EMERGENCY MEDICAL CARE OR PRE-EXISTING MEDICAL CONDITIONS WHILE IN TRANSCOR'S CUSTODY. ALL PRISONER MEDICAL COSTS, INCLUDING, BUT NOT LIMITED TO, THE COSTS OF TRANSPORTATION TO AND FROM ANY MEDICAL FACILTIY FOR INCIDENTS NOT DIRECTLY RESULTING FROM TRANSCOR SHALL BE PAID BY THE CUSTOMER AGENCY. YOU ALSO AGREE THAT TRANSCOR IS AUTHORIZED TO OBTAIN EMERGENCY AND/OR ROUTINE MEDICAL TREATMENT FOR THE PRISONER WHENEVER DEEMED NECESSARY. IN ADDITION YOU AGREE THAT TRANSCOR WILL BILL YOU AN ATTEMPTED PICK CHARGE EQUAL TO THE MINIMUM CHARGE WHEN A PRISONER IS NOT PICKED UP DUE TO NO FAULT OF TRANSCOR. TRANSCOR WILL REPORT ALL SUCH EXPENDITURES IN DETAIL TO THE CUSTOMER AGENCY.