## STATE OF ALASKA DEPARTMENT OF CORRECTIONS

## Individual Determination Restriction(s) Form:

Date Removed Supt Initials

Prisoner Name:	
Offender #:	

Restriction

No Group/ Program Activities

Legal/Ombudsman Calls Only

DILL Only/No Library Access

Separate Status Two (2) Officer Coverage Out of cell leg irons Out of cell handcuffs Out of cell waist chains Handcuff retainer Spit Hood/Mask Recreate Alone

No Typewriter In-cell phone only Finger Food/Bag Meals \* Suicide Blanket/Gown only \*

In-Cell Meals Only No Container Secure Visitation Only

Dry cell procedures

No Mattress \* No Linen/Clothes \*

No Razor

Date:	
TO:	
	Superintendent
From:	
	COIII/COIV
	Supporting documentation is on file in the prisoner's record. These restrictions will be reviewed at intervals not to exceed thirty (30) days. Loss of bedding, clothing or food (*) must be reviewed every 48 hours or the next business day.
Superintende	ent:
	Approve Disapproved
Date Rest	trictions lifted:
By:	
Reason	
neuson	
Comments:	

The reason for each restriction is:

48 hour/30 Day Review			
Restriction		Ву	Date

48 hour/30 Day Review				
Restriction	Ву	Date		



**COIII/IV** Initials



## STATE OF ALASKA DEPARTMENT OF CORRECTIONS

Prisoner Name:

Offender #:

Restriction reason and thirty (30) day or 48 hour reviews continued:

Reviewed

	r/30 Day Review	
Restriction	Ву	Date
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48 hour/30 Day Review			
Restriction	Ву	Date	
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