

NEW YORK STATE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
REPORT OF GRAVE ILLNESS / DEATH IN INMATE'S FAMILY

Photocopy as needed
FORM 4206A (9/14)

_____ CORRECTIONAL FACILITY

1. TO BE COMPLETED BY CHAPLAIN OR SORC OR WATCH COMMANDER

Inmate: _____ DIN: _____ Unit: _____ CMC: _____

Caller: _____ Relationship: _____

Address: _____ Telephone No: _____

Name of Sick/Deceased: _____ Relationship: _____

Address: _____

Call Taken: Date: _____ Time: _____ By Whom: Name: _____ Title: _____

Chaplain or SORC Notified: Name: _____ Date: _____ Time: _____

2. TO BE COMPLETED BY CHAPLAIN OR SORC

Confirmation of Grave Illness / Death Made By: Name: _____ Title: _____

Date: _____ Time: _____

Location Called For Conf: _____ Person Contacted: _____

Death / Grave Illness: Cause / Nature: _____ Date: _____

Relationship Confirmed By: Name: _____ Title: _____

Is Inmate's Presence Requested: Yes No

Chaplain or SORC Met With Inmate: Date: _____ Time: _____ Does Inmate Wish To Attend: Yes No

Name: _____ Title: _____

3. HOSPITAL: _____ Telephone No: _____

Address: _____

Contact Person: _____ Title: _____

4. FUNERAL HOME: _____ Telephone No: _____

Address: _____

Contact Person: _____ Title: _____

Calling Hours: Date: _____ Time: _____ Location: _____

Funeral Service: Date: _____ Time: _____ Location: _____

Remarks: _____

5. OTHER INCARCERATED FAMILY MEMBERS: List Name(s), DIN(s), and Owing Facility _____

Prepared By: _____ Title: _____

6. TO BE COMPLETED BY SUPERINTENDENT OR DESIGNEE

Trip Approved: _____ Disapproved: _____ Reason (if Disapproved): _____

By: _____

Superintendent or Designee

Other Considerations, if any: _____

Additional Information: _____ Yes **see attachment(s)** _____ No

cc: Executive Team (1)
Guidance

Watch Commander
Movement & Control

Chart Sgt.
Chaplains (1)

Inmate Records