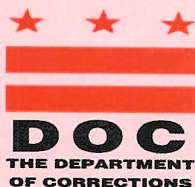


DOC Staff: Print Name _____ Sign Name _____ Date _____



DISTRICT OF COLUMBIA
DEPARTMENT OF CORRECTIONS
**INMATE INFORMAL RESOLUTION
COMPLAINT FORM**

TO BE COMPLETED BY INMATE GRIEVANCE
COORDINATOR

IGP NUMBER:

STEP 1: INFORMAL RESOLUTION (To be completed by Inmate)

- Inmate has five (5) days after triggering incident to submit request.
- Place this form in the housing unit IGP box. The IGP coordinator will respond within seven (7) business days.

INMATE NAME:

DCDC#:

UNIT:

DATE:

Ryan Nichols

376795

C-2B

11/15/21

SELECT DEPARTMENT/SERVICES NEEDED:

- ☐ Facility Transfer
- ☐ Fire Safety and Sanitation /Risk Management
- ☐ Program and Activities
- ☐ Personal Hygiene
- ☐ Case Management Services
- ☒ Health Care
- ☐ Communications (mail, visits, telephone, legal)

- ☐ Property
- ☐ Sentence computation, jail credit, over detention
- ☐ Finance
- ☐ Rules and Regulations
- ☐ Staff Treatment
- ☐ Food Service
- ☐ Religious Services

- ☐ Facilities Management
- ☐ Discrimination
- ☐ Transportation
- ☐ Safety and Security
- ☐ Other

DATE OF INCIDENT: 11/15/21 TIME OF INCIDENT: 10:30 AM OFFENDER: MEDICAL

REASON FOR COMPLAINT: I was seen at medical on 11/8/21 for an ear ache/ear infection. Medical found liquid in my right ear, and prescribed me meds. I've asked multiple times for the meds, including multiple medical request and speaking with medical directly. The Nurse/Dr apologized and said they must have overlooked my prescription. My ear is now healing worse, and I'm using my meds. Thank you

INMATE SIGNATURE: _____ DATE: 11/15/21

*** FOR DOC COMPLETION *** Provide response to the IGP Coordinator no later than _____.

DOC RESPONSE: _____

PRINT RESPONDER NAME: _____ RESPONDER SIGNATURE: _____ DATE: _____

DEPARTMENT: _____ MANAGER NAME: _____ MANAGER SIGNATURE: _____

INMATE GRIEVANCE COORDINATOR SIGNATURE: _____ DATE: _____