DOC Staff: Print Name_____ Sign Name_____ Date _____

DOC
THE DEPARTMENT OF CORRECTIONS

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 2 B	1/7/22

SELECT DEPARTMENT/SERVICES NEEDED:

○ Facility Transfer	○ Property	○ Facilities Management
○ Fire Safety and Sanitation /Risk Management	○ Sentence computation, jail credit, over detention	○ Discrimination
○ Program and Activities	○ Finance	○ Transportation
✓ Personal Hygiene	○ Rules and Regulations	○ Safety and Security
○ Case Management Services	○ Staff Treatment	✓ Other
✓ Health Care	○ Food Service	
○ Communications (mail, visits, telephone, legal)	○ Religious Services	

DATE OF INCIDENT: 1/7/22 **TIME OF INCIDENT:** All Day **OFFENDER:** DC DOC

REASON FOR COMPLAINT: This is about the state of my mental health being affected by DC DOC Policies as a Pre-trial detainee. I have not been afforded a haircut/shave since arriving here on March 9, 2021, even though I have met all requirements by the Jail. I've also been denied family visits, attorney visits, religious services, and banished to solitary confinement even though I became fully vaccinated like the Jail told me to do in order to receive these things. I feel like a horse being led along with a dangling "carrot" in front of me. That "carrot" is my constitutional rights and better treatment promised, but no matter what I do to please the Jail, better treatment never comes. My Mental health is

INMATE SIGNATURE: _____ **DATE:** 1/7/22

***** 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:** _____