MAINE DEPARTMENT OF CORRECTIONS

REQUEST FOR LOWER CUSTODY LEVEL, MEDIUM CUSTODY TRUSTEE STATUS, OR TRANSFER

Resident's Name: _____ MDOC#: _____

Facility/Housing Unit: _____ Case Manager: _____

1. Nature of request: _____
2. Reason and information in support of the request:

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3. Other pertinent information:

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☐ Interim Reclassification Review Recommended

☐ Interim Reclassification Review Not Recommended (specify reasons): _____

_____

_____ Date_____

Signature of UM, or designee

Decision of Director of Classification, or designee

☐ Approved for Review

☐ Not Approved for Review (specify reasons): _____

_____

NOTE: IF APPROVED FOR REVIEW, AN INTERIM RECLASSIFICATION MUST BE CONDUCTED WITHIN THIRTY (30) DAYS

_____ _____

Signature of Resident Date

_____ _____ _____

Signature of Staff Date Printed Name and Title

NOTE: RESIDENT IS TO BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED BY THE RESIDENT AND THE STAFF.