ILLINOIS PRISONER REVIEW BOARD

MEDICAL RELEASE REQUEST

The undersigned Applicant prays for a grant of Medical Release and in support thereof states as follows:

1. **Required Applicant Information:**

Applicants Full Name: _____
First Middle Last

Current Holding Facility: _____

Date of Birth: _____ Place of Birth: _____

Social Security Number: _____

State Prisoner Number: _____

Race/Ethnicity: _____ Gender: _____

Have you applied for Medical Release before? Yes ☐ No ☐
If yes, please provide the Application number(s) and date(s) of denial.

_____

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Have you ever petitioned for clemency before? ☐ Yes ☐ No
If yes, please state the month and year your petition was considered.

_____

_____

Would you, the Applicant/Attorney/representative, like to request a public hearing?

☐ Yes ☐ No

2. Conviction(s) for Which Medical Release is Sought:

For each conviction please provide the following information:

Offense: _____

Case Number: _____

County of Conviction: _____

To the best of your ability, provide a complete detailed account of the offense(s) for which you seek Medical Release. Provide your **<u>own</u>** version of the factual circumstances of the offense(s), including the date and location, if possible. *<u>Add additional pages if necessary</u>*.

_____

_____

_____

_____

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3. Diagnostic Medical Criteria:

The Applicant must meet one, or more, of the following diagnostic medical criteria to be eligible for review for Medical Release, please check the appropriate option(s), see definitions:

_____ Applicant is suffering from a terminal illness likely to cause death to the Applicant within 18 months.

_____ Applicant has been diagnosed with a condition that will result in medical incapacity within the next 6 months.

_____ Applicant has become medically incapacitated subsequent to sentencing due to illness or injury.

Please state, <u>briefly</u>, what the qualifying medical condition is that the applicant is requesting relief for.

_____

_____

<u>Terminal Illness</u>: A condition that satisfies all of the following criteria:

i. The condition is irreversible and incurable

ii. In accordance with medical standards and a reasonable degree of medical certainty, based on an individual assessment of the Applicant, the condition is likely to cause death to the Applicant within 18 months.

<u>Medically Incapacitated</u>: An Applicant has any diagnosable medical condition, including dementia and severe, permanent medical or cognitive disability, that prevents the Applicant from completing more than one activity of daily living without assistance or that incapacitates the Applicant to the extent that institutional confinement does not offer additional restrictions, and that the condition is unlikely to improve noticeably in the future.

4. **Parole Plan (Host site information).** Please provide a parole plan stating a potential, or already approved, location that the Applicant would be able to reside at.

   If this is a place of business, please provide the following information:

   _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   If this is a residence, please provide the following information:

   _____
   Name of homeowner or leaseholder

   Address: _____

   City: _____ State: _____ Zip Code: _____

   _____ _____
   Phone number Relationship to Applicant

   Will there be someone available at the residence to care for and ensure Applicant is transported to medical appointments?

   _____ Yes _____ No

If no host site is provided, are you willing to accept placement approved by the Illinois Department of Corrections based on your level of care?

_____ Yes _____ No

5. **Certification and Personal Oath.** The following certification and personal oath must be signed by the Applicant, Attorney for the Applicant or a representative of the Applicant.

I declare under perjury that all of the assertions made in this petition are complete, truthful and accurate.

Respectfully submitted this _____ day of _____, _____.
(*Month*) (*Year*)

_____
(*Signature*)

If the Applicant <u>is not</u> the one filing on their own behalf, please provide the following information:

Full Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone No.: _____

Valid Email Address: _____

Relationship to Applicant: _____

Do you have a General or Medical Power of Attorney (POA) for the Applicant?

_____ Yes _____ No

If yes, please include a copy of the POA documents/order naming such person, if possible.

Optional information to include in the application, but not required:

1) The following information may be typed/legibly written out and included with the application, but not required:

    a. Personal life history
    b. Educational background
    c. Marital status
    d. Names and ages of children
    e. Substance abuse and mental health information
    f. Military Records and/or awards*
    g. Degrees or diplomas* (earned or anticipated)
    h. Awards or commendations*
    i. Counseling or rehabilitation programs you have attended or completed*
    j. Licenses or certifications*
    k. Life changing events

    **Supporting documentation. Claims made within the application is to be supported by documentation, whenever possible. For example, attach materials that support the claims made in this application may include DD-214, diplomas, certifications, etc.*