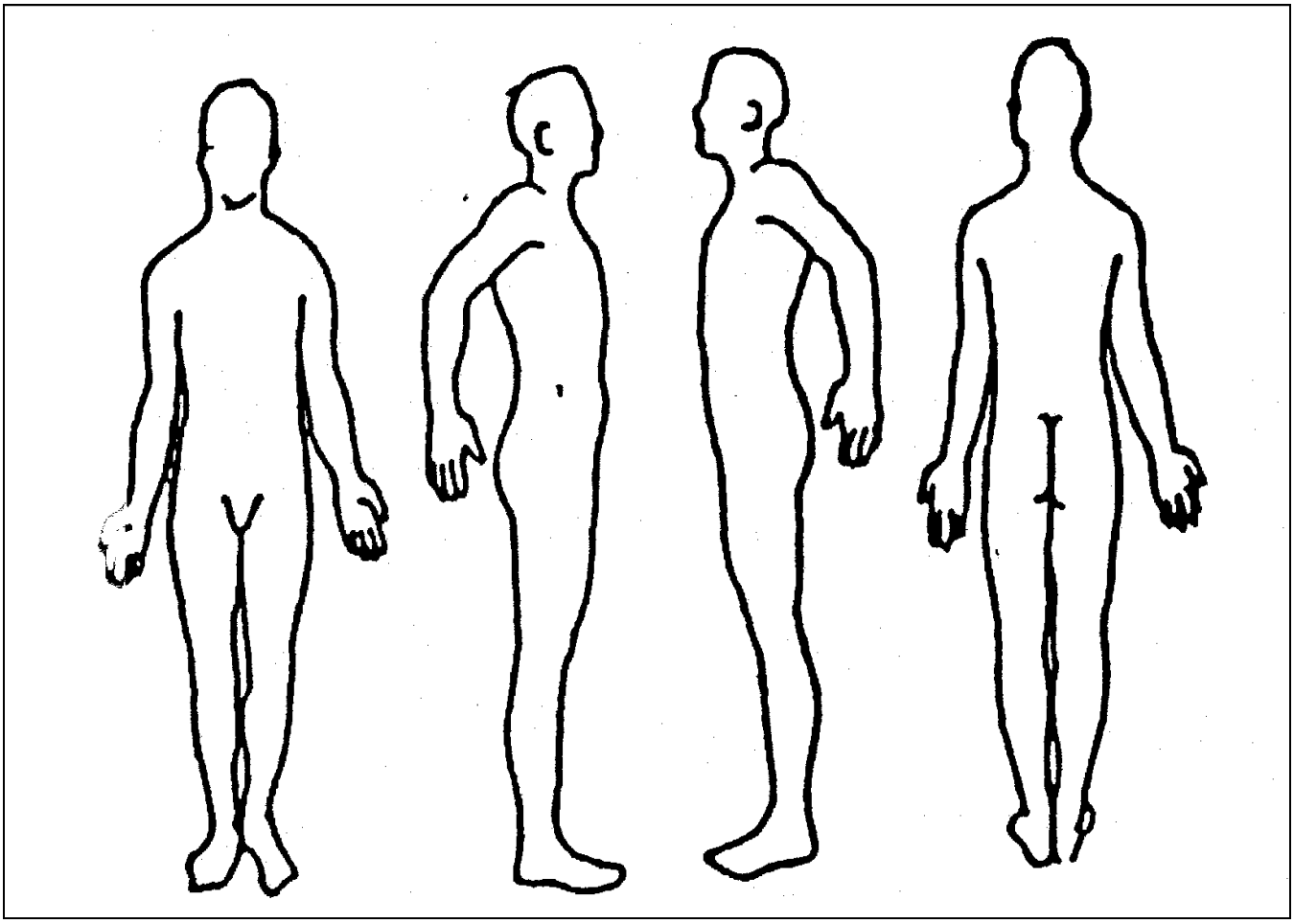
FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF HEALTH SERVICES
DIAGRAM OF INJURY



Date of occurrence _____ Time of occurrence _____
Date injury assessed by medical _____ Time injury assessed by medical _____

☐ No injury identified

Description of injury _____

_____

_____

_____

_____

_____
Staff Signature

Inmate Name_____
DC#_____Race/Sex_____
Date of Birth _____
Institution_____

This form is not to be amended, revised, or altered without approval by the Office of Health Services- Administration

DC4-708 (Effective 10/07)

Incorporated by Reference in Rule 33-602.210, F.A.C.