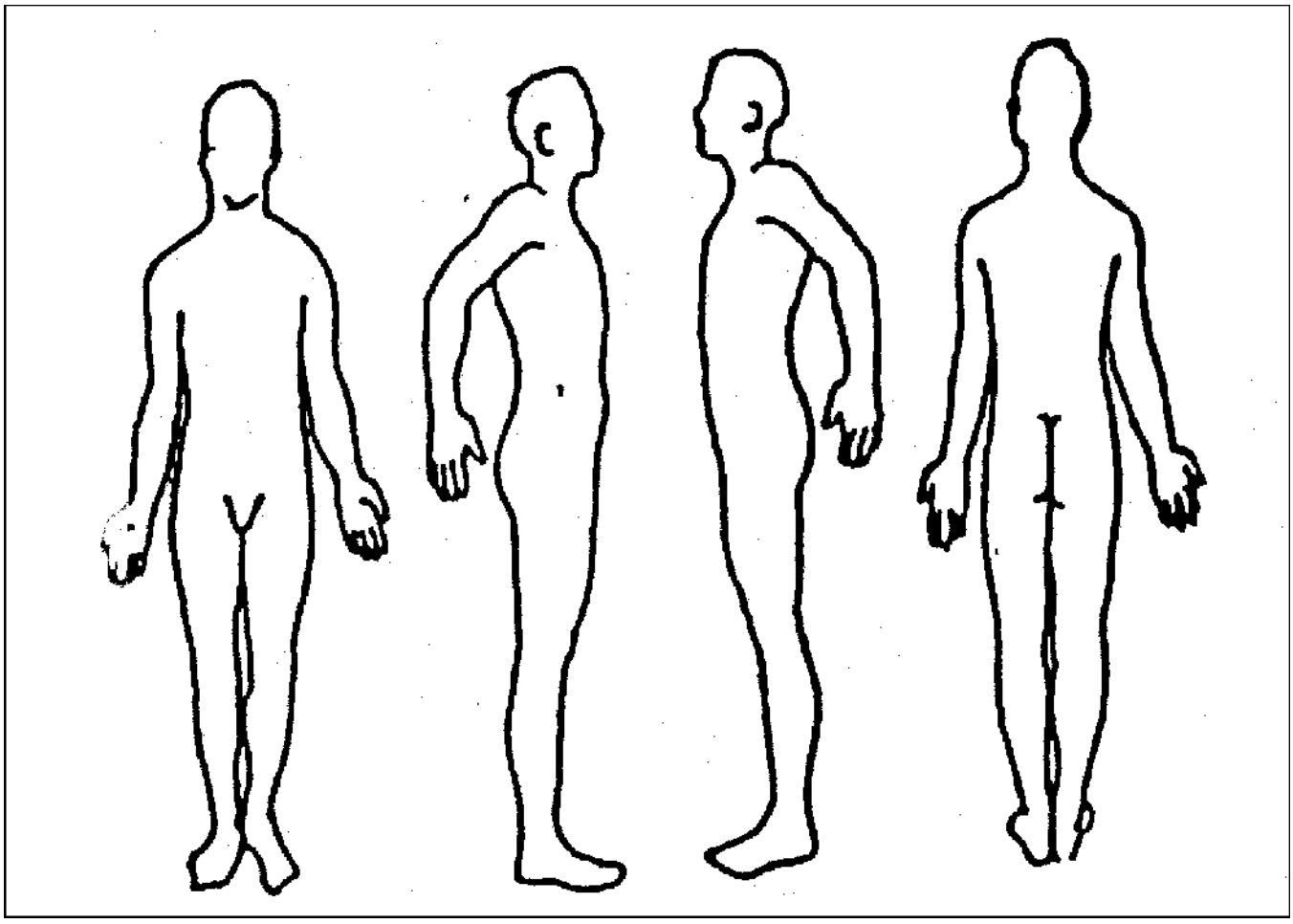
FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF HEALTH SERVICES
DIAGRAM OF INJURY



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 Director of Health Services- Administration.

Copies distribution: White/Health Record Canary/Inspector General Pink/Warden or Asst. Warden

DC4-708 (Revised 10/07)

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