



**Florida Department of Corrections
Report of Placement in Restrictive Housing for Pregnant Inmates**

DC#: _____ **Inmate Name:** _____ **Facility:** _____

Initial Placement Date: _____

Initial Placement Time: _____

Placement: _____

Reason Restrictive Housing is necessary:

Comments:

Reason less restrictive means are not available:

Comments:

Qualified healthcare professional at the institution objects to the placement? _____

Qualified healthcare professional:

Name: _____ **Signature:** _____ **Date:** _____

Senior Correctional Officer or above:

Name: _____ **Signature:** _____ **Date:** _____

Copy provided to inmate? _____ **on** _____ **at** _____
(Date) (Time)

CC: Inmate File