STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

APPLICATION FOR FACILITY ACCESS

NAME (PRINT)			
ADDRESS 3547 Olive St. Suite 250			DATE OF BIRTH (M/D/YY)
CITY St. Louis	STATE MO	ZIP CODE 63103	GENDER ☐ MALE ☐ FEMALE
TELEPHONE NUMBER(S) (314) 289-4190	SOCIAL SECURITY NUMBER or Missouri D.L.#		
INSTITUTION TO BE ACCESSED WERDCC	DOC STAFF CONTACT Angelica Boyd		
PROGRAM/AGENCY REPRESENTED Prison Performing Arts			

1. I have been provided a list of approved items and dress code for the facility.
2. In visiting the Department of Corrections, I may be in circumstances involving risks or hazards. I willingly and knowingly accept these conditions.
3. I agree to:
   a. Take nothing, including letters, in or out of any correctional center without approval from administration
   b. Respect the confidentiality of records and other privileged information
   c. Refrain from using abusive or profane language
   d. Refrain from taking photographs on institutional property for any purpose without specific permission from the administration
   e. Refrain from giving/leaving anything behind for use by an offender without approval from administration
   f. Refrain from inappropriate signs of affection
   g. Obey any custody staff order
   h. Not discriminate
   i. Refrain from racially inflammatory speech, disparaging other religions or directly addressing issues of confinement
4. I am not related to any offender in Missouri Department of Corrections custody at the facility that I am accessing.
5. I am not on any offender visiting list at the facility that I am accessing.
6. All vehicles will have doors locked, windows up and key removed from ignition
7. No drugs are allowed in the institution except a personal one-day supply of prescribed medication in the original prescription container.
8. I authorize Missouri Department of Corrections to conduct a Criminal History Check Screening.
9. I understand I cannot enter the facility until the institutional activities coordinator has received this application, it has been approved and my name has been added to the Approved Entry Roster.
10. Failure to abide by this agreement or violation of any state or federal law during my visit may result in sanctions including arrest and prosecution.
11. I agree to comply with departmental tuberculosis testing, as applicable.

SIGNATURE	DATE

APPROVALS

IAC SIGNATURE		DATE
MULES/NCIC	CAO	DATE

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

STAFF SEXUAL MISCONDUCT AND HARASSMENT ACKNOWLEDGEMENT

EMPLOYEE NAME (PLEASE PRINT)	
LAST 4 DIGITS OF SOCIAL SECURITY NUMBER	WORKSITE

I acknowledge on this date, I have received a copy of "Staff Sexual Misconduct and Harassment: A Guide for Staff, Contractors and Volunteers". I have been briefed on its contents and understand I can be disciplined for the conduct described therein.

EMPLOYEE SIGNATURE	DATE
WITNESS NAME (PLEASE PRINT)	DATE
WITNESS SIGNATURE	

DISTRIBUTION: EMPLOYEE PERSONNEL OFFICIAL FILE

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

WAIVER OF TUBERCULOSIS TESTING

NAME (PRINT)

SOCIAL SECURITY NUMBER

DATE OF BIRTH

PROGRAM/AGENCY REPRESENTED

THIS IS TO CONFIRM THAT I **DO NOT** HAVE SYMPTOMS CONSISTENT WITH TUBERCULOSIS. PLEASE CHECK ANY OF THE FOLLOWING COMMON SYMPTOMS OF TUBERCULOSIS THAT YOU HAVE:

- ☐ night sweats (waking up from sleep drenched in sweat)
- ☐ unexplained fever (fever for several weeks, unrelated to a known illness)
- ☐ chronic cough lasting longer than three weeks
- ☐ coughing up blood
- ☐ loss of appetite/unexplained weight loss
- ☐ feeling tired all the time and/or being really weak
- ☐ I do ☐ do not have any of these symptoms
- ☐ I have ☐ have not had recent contact with someone with contagious tuberculosis.

To the best of my knowledge, I do not have contagious tuberculosis.

I understand the risk for tuberculosis exposure involved in accessing DOC facilities.

I hereby waive the TB testing provided by the DOC.

I am aware that this waiver of testing is effective for this visit at this facility only.

I am aware that I can waive TB testing five times per year before required to submit to TB testing.

SIGNATURE	DATE
STAFF WITNESS SIGNATURE	DATE

DISTRIBUTION: FAX TO EMPLOYEE HEALTH AND SAFETY AT (573) 526-2608