



**DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS
BOP TRIBAL PRISONER PROGRAM**

Directions: Please fill out this form in its entirety and with as much detail as possible. This information is needed to appropriately evaluate the security and programming needs of the offender. Attach additional pages if necessary. This form may be replicated, but should include all information in the order and format provided below.

Case Summary

Personal Data

Name:		
Date of Birth:	Gender:	
Place of Birth:		
Height:	USMS#:	
Weight:	FBI#:	
Eye Color:	SSN#:	
Hair Color:	State#:	
Race:	DOC#:	
Citizenship:		
Tribal Affiliation:		
Home Address:		
Family Data (<i>Martial Status, Children, etc...</i>):		
Employment History:		

Social Data

Level of Education Achieved (<i>Include Vocation Training</i>):			
History of Substance Abuse:	Yes	No	Date of Last Use:
<i>If Yes, Include Substances Used:</i>			

Sentence Data Summary

Current Offense:	
Docket/Case No.:	Tribal Jurisdiction:
Sentence Imposed:	Name of Judge:
Date Imposed:	Release Date:
Fines / Assessments / Restitution:	
Offense Conduct (<i>Description of Offense</i>):	
Tribal Criminal Code for Current Offense (<i>By examination of the relevant Tribal criminal code provision(s), BOP must confirm that the current conviction is for an offense comparable to crimes listed in 18 U.S.C. § 1153(a)</i>):	
Detainer/Pending Charges/Outstanding Warrants: <i>If Yes, Include Charges, Agency and Contact Information.</i>	Yes No
Prior Record (<i>Include all Arrests, Offense Conduct and Dispositions</i>):	
Victim Notification:	Yes No
<i>If Yes, Please Complete Last Page of Attachment – Request for Victim Notification</i>	

Escape History

Yes	No	<i>If Yes, Include Dates, Offense Conduct and Disposition.</i>
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Gang Affiliation

Yes	No	<i>If Yes, Name Affiliation:</i>
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Medical & Mental Health Summary

Current Medical Condition:
Current Medications:
Medical Devices Used:
Current Mental Health History:
Past Mental Health History:

Medical & Mental Health Summary *(Continued)*Current Medications *(Mental Health)*:Psychological Evaluation *(If Applicable)*:**Institution Adjustment at Current Correctional Facility**Type and Number of Incident Reports/Rule Infractions *(Include description of incident, date, finding of guilt, and any sanctions imposed)*:

Educational/Counseling Program Participation:

Tribal Court Address

Tribal Court:

Street Address:

Street Address:

City:

State:

Zip Code:

Certification

Prepared By	Certified By (Judge or Court Representative)
Printed Name:	Printed Name:
Title:	Title:
Date:	Date:
Phone Number:	Phone Number:
Signature:	Signature: