WORK CAMP GOOD TIME

Notice of LOSS OF CAMP GOOD TIME

☐ **CRFC** ☐ **MVRCF** ☐ **NECC** ☐ **NSCF** ☐ **NWSCF** ☐ **SSCF**

INMATE NAME: _____

Last *First* *Middle Initial*

INMATE DATE OF BIRTH: _____

DATE LOST (M/Y): _____

Due to (an) infraction(s) committed on _____

The Disciplinary Committee recommends the lost of _____ days of Camp Good Time in Accordance with 28 VSA 812 for the following reason(s):

_____

_____

_____

Hearing Officer Signature: _____ Date: _____

Superintendent/Designee Signature: _____ Date: _____

MIN Rel: _____ / _____ / _____

Month **Day** **Year**

MAX Rel: _____ / _____ / _____ _____

Month **Day** **Year** **Staff Initials**

Offender has 30 days to grieve any loss of Camp Earned Reduction of Term. Failure to grieve within that period shall constitute a waiver of any complaint regarding the loss.

Original: Upload into OMS; Copy: Inmate