

Name:			IA #:		
Address:					
City:		State:	Zip Code:		Phone #:
DOB:		SSN:	Age:		Sex: Race:
Employer/School:				Phone:	
Address:					
City:		State:	Zip Code:		Phone #:
<b>INCIDENT</b>					
Nature of Complaint:					
Complaint Against:				Badge/ID #:	
Complaint Against:				Badge/ID #:	
Date:	Time:	Date/Time Reported:		How Reported:	
Incident Location:				Case #:	
Description of Incident:					
Description of Any Injuries:					
Place of Treatment:			Doctor's Name:		Date of Treatment:
Signature of Complainant:				Date:	
<i>Providing false information, written or verbal to authorities is a crime. I understand that if I provide false information to authorities I will be prosecuted. _____ (initial)</i>					
Action Taken:					
<input type="checkbox"/> Referred to Other Agency: _____ Agency name/representative					
<input type="checkbox"/> Forwarded to Internal Affairs Unit: _____ Date forwarded					
Employee Taking Complaint:			Badge/ID#:		Date: