

PROSECUTION INTAKE FORM

PLEASE FILL OUT THE COMPLAINT / AFFIDAVIT FORM, AND TELL WHAT HAPPENED, IN AS MUCH DETAIL AS POSSIBLE. ATTACH STATEMENTS, PHOTOS, AND OTHER EVIDENCE TO SUPPORT YOUR CASE. (ALSO NOTE THE COMPLAINANT MUST BE THE AGE OF 18 YEARS OLD, OTHERWISE- THE PARENT OR LEGAL GUARDIAN MUST FILE THE COMPLAINT ON BEHALF OF THE VICTIM.)

TODAY'S DATE: ___/___/___ CASE #: _____

VICTIM'S NAME: _____ D.O.B.: ___/___/___ AGE: _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____

PHONE #:(____)-/____/____ CELL PHONE #:(____)-/____/____ WORK #:(____)-/____/____

DATE OF INCIDENT: ___/___/___ (MM/DD/YYYY) TIME OF INCIDENT: ____:____ AM / PM

PLACE INCIDENT OCCURRED: _____

PERSON(S) YOU ARE ACCUSING: 1: _____, 2: _____,

3: _____, 4: _____, 5: _____

(IF YOU NEED ADDITIONAL SPACES PLEASE ATTACH A SECOND SHEET)

ARE THESE INDIVIDUALS UNDER THE AGE OF EIGHTEEN (18): (_Y_) (_N_)

NAME(S) OF WITNESSE(S): 1: _____, 2: _____,

3: _____, 4: _____, 5: _____

(IF YOU NEED ADDITIONAL SPACES PLEASE ATTACH A SECOND SHEET)

WAS AN OFFICER CALLED: (_Y_) (_N_)

IF SO, WHO WAS THAT OFFICER: (CPS) (BLES) (OTHER): _____ BADGE #: _____

WAS THE VICTIM TAKEN TO THE HOSPITAL OR SEEN BY A PHYSICIAN: (_Y_) (_N_)

IF YES, PLEASE PROVIDE A COPY OF THE PHYSICIAN'S REPORT TO THE ABOVE OFFICER / OR ATTACH IT TO THIS FORM. (A MEDICAL RELEASE FORM FROM THE HOSPITAL IS / MAY BE REQUIRED)

WERE PICTURES TAKEN OF ANY DAMAGES OR INJURIES TO THE VICTIM, OR PROPERTY: (_Y_) (_N_) IF YES, PLEASE PROVIDE A COPY OF THOSE PHOTOS TO THE ABOVE OFFICER / OR ATTACH THEM TO THIS FORM.

DO YOU FEAR FOR YOUR SAFETY: (_Y_) (_N_) -(CLARIFY IN YOUR WRITTEN STATEMENT)

DO YOU FEAR FOR THE SAFETY OF YOUR PROPERTY: (_Y_) (_N_) -(CLARIFY IN YOUR WRITTEN STATEMENT)

DO YOU WANT A RESTRAINING ORDER: (_Y_) (_N_) -(CLARIFY IN YOUR WRITTEN STATEMENT)

COMPLAINANTS SIGNATURE: _____ DATE SIGNED: _____

OFFICER'S SIGNATURE: _____ DATE SIGNED: _____ BADGE #: _____

IN THE EVENT THAT THE VICTIM WAS TAKEN TO A HOSPITAL AND SEEN BY A NURSE PRACTITIONER, PHYSICIAN'S ASSISTANT, PHYSICIAN, OR BY PERSONS MEDICALLY QUALIFIED TO DO SO- THE BELOW MUST BE CHECKED BY THAT SAID PROFESSIONAL. THE INJURIES SUSTAINED BY THE VICTIM CONSTITUTE AS: [] MINOR [] MODERATE [] SEVERE [] OTHER- _____ INITIALS OF MEDICAL PROFESSIONAL OF WHOM SAW THE VICTIM, AND CHECKED THE ABOVE: _____ DATE: ___/___/___ THE BLACKFEET LAW ENFORCEMENT OFFICER THAT BROUGHT THIS FORM TO YOUR ATTENTION WAS BADGE # _____

A NOTE FOR THE OFFICER: IN THE EVENT THAT LINE NUMBERS 35, AND 39 ARE CHECKED YES- THAT INFORMATION IS REQUIRED BEFORE YOU CAN TURN THIS INTO THE PROSECUTION

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I, _____, UNDERSTAND THAT THE INFORMATION THAT I PROVIDE MAY BE USED TO FILE A CRIMINAL COMPLAINT AGAINST THE PERSON(S) THAT I AM ACCUSING AND THAT IF I PROVIDE FALSE INFORMATION, I MAY FACE CRIMINAL CHARGES AGAINST ME.

I, _____, DO SWEAR THE INFORAMTION CONTAINED IN THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE.

DATE THIS _____ DAY OF _____, 20____.

OFFICER'S INITIALS: _____ BADGE # _____