



## **Incident Report Form**

*The purpose of this incident report form is to assist advocates and people experiencing homelessness in tracking cases of abuse and/or mistreatment. The victim's signature at the end of the form indicates his/her consent to use the information in reports and/or presentations to various groups, including the media. The victim should not sign the form if s/he does not consent. (See signature instructions at the end).*

Report Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

### **Information of Victim (optional)**

Name: \_\_\_\_\_

Address or Way to Contact: \_\_\_\_\_

Phone Number or Way to Contact: \_\_\_\_\_

Email: \_\_\_\_\_

**Victim's Identity/Characteristics (optional):** *This information may help to determine factors that have played a role in the incident. Fill out any applicable category.*

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Race: \_\_\_\_\_ Religion: \_\_\_\_\_

Ethnicity/National Origin: \_\_\_\_\_ Sexual Orientation: \_\_\_\_\_

Disability: \_\_\_\_\_ Other Factors: \_\_\_\_\_

### **Incident Specifics**

Date of Incident: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Location: *(Be as specific as possible, for example, on the corner of E. 17<sup>th</sup> and Superior between the bus stop and the hot dog stand).* \_\_\_\_\_

Losses/Grievances: *(e.g. destruction or confiscation of property, arrest, arson, assault/battery, murder)* \_\_\_\_\_

Injuries Suffered: \_\_\_\_\_

Medical Attention: *(Name of Hospital/Doctor)* \_\_\_\_\_

Hospital Intake Date: \_\_\_\_\_ Hospital Release Date: \_\_\_\_\_

*(Continued on Back)*

**Description of Incident:** *Include as many factual details as possible, e.g. any police response and involvement and any witness information. Use back or attach sheets if necessary.*

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**Persons Involved**

Number of people involved in incident: \_\_\_\_\_ Gender(s): M \_\_\_ F \_\_\_

Race(s): \_\_\_\_\_ Approximate age(s): \_\_\_\_\_

Other Physical Characteristics: *(Clothing, facial features, body type(s))* \_\_\_\_\_

Method of Transportation: \_\_\_\_\_ Weapons Used: \_\_\_\_\_

**Resolution/Outcome (If Any):** *What would you like to be done? Which results do you desire?*

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**Signature:** *Your signature immediately below indicates your consent for us to use the information on this form in reports and/or presentations to various groups, including the media. This refers to information only; actual names/identification of individual victims will be withheld as a matter of course unless otherwise agreed to in advance. You DO NOT have to sign here if you do not consent.*

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**Witness (If Any)**

Name: \_\_\_\_\_

Address or Way to Contact: \_\_\_\_\_

Phone Number or Way to Contact: \_\_\_\_\_ Email: \_\_\_\_\_

If Police Were Involved, Name of Officer: \_\_\_\_\_ Badge #: \_\_\_\_\_

**Thank you.**