

INCIDENT REPORT

PAGE 1 OF 2

ESTABLISHMENT INFORMATION

Corporate Name			Doing Business As		
Date of Incident	Time of Incident <input type="checkbox"/> AM <input type="checkbox"/> PM	Location of Incident	<input type="checkbox"/> Coat Check <input type="checkbox"/> Dance Floor	<input type="checkbox"/> Bar <input type="checkbox"/> Outside	<input type="checkbox"/> Rest Room <input type="checkbox"/> Other (Specify)
Report Prepared By			Signature		Date of Report

PATRONS INVOLVED OR WITNESSING INCIDENT (Use Additional Form(s) if Necessary)

1. Name		<input type="checkbox"/> Victim <input type="checkbox"/> Aggressor <input type="checkbox"/> Witness		Race	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Amer. Ind.	<input type="checkbox"/> White Hispanic <input type="checkbox"/> Black Hispanic <input type="checkbox"/> Asian/Pacific Isl	<input type="checkbox"/> Other (Specify)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	Eye Color	Hair Color	Date of Birth	ID Source	
Address			Apt. No.	City	State	Zip Code	
Home Phone No.		Cellphone No.	Business Phone No.		Fax No.	Email Address	
Vehicle Make/Model/Color					License Plate or Taxi Medallion No.		
Distinguishing Marks (Describe Any Scars Tattoos etc.)							

Was Patron Asked To Leave Premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patron Escorted From Premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, How Was Patron Escorted From Premises			
Did Patron Resist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Describe			Was Intoxication Noticeable Before Or After The Incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

2. Name		<input type="checkbox"/> Victim <input type="checkbox"/> Aggressor <input type="checkbox"/> Witness		Race	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Amer. Ind.	<input type="checkbox"/> White Hispanic <input type="checkbox"/> Black Hispanic <input type="checkbox"/> Asian/Pacific Isl	<input type="checkbox"/> Other (Specify)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	Eye Color	Hair Color	Date of Birth	ID Source	
Address			Apt. No.	City	State	Zip Code	
Home Phone No.		Cellphone No.	Business Phone No.		Fax No.	Email Address	
Vehicle Make/Model/Color					License Plate or Taxi Medallion No.		
Distinguishing Marks (Describe Any Scars Tattoos etc.)							

Was Patron Asked To Leave Premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patron Escorted From Premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, How Was Patron Escorted From Premises			
Did Patron Resist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Describe			Was Intoxication Noticeable Before Or After The Incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

3. Name		<input type="checkbox"/> Victim <input type="checkbox"/> Aggressor <input type="checkbox"/> Witness		Race	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Amer. Ind.	<input type="checkbox"/> White Hispanic <input type="checkbox"/> Black Hispanic <input type="checkbox"/> Asian/Pacific Isl	<input type="checkbox"/> Other (Specify)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	Eye Color	Hair Color	Date of Birth	ID Source	
Address			Apt. No.	City	State	Zip Code	
Home Phone No.		Cellphone No.	Business Phone No.		Fax No.	Email Address	
Vehicle Make/Model/Color					License Plate or Taxi Medallion No.		
Distinguishing Marks (Describe Any Scars Tattoos etc.)							

Was Patron Asked To Leave Premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patron Escorted From Premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, How Was Patron Escorted From Premises			
Did Patron Resist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Describe			Was Intoxication Noticeable Before Or After The Incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

INCIDENT REPORT

PAGE 2 OF 2

POLICE INFORMATION

Were Police Called? <input type="checkbox"/> Yes <input type="checkbox"/> No	Responding Officer (Rank, Name)	Officer's Shield No.
Visible Injuries to Patron(s):	Complaint Report Taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	Complaint No.
SPRINT No.: (Can be obtained from Responding Officer)		

Were Medical Services Offered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were Medical Services Refused? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did EMS/Ambulance Service Respond? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patron(s) Removed? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--	--

INCIDENT INFORMATION

Employees Involved (Describe How Below)

Name _____ Home Phone No. _____ Cell Phone No. _____

Name _____ Home Phone No. _____ Cell Phone No. _____

Name _____ Home Phone No. _____ Cell Phone No. _____

Employees Witnessing Incident

Name _____ Home Phone No. _____ Cell Phone No. _____

Name _____ Home Phone No. _____ Cell Phone No. _____

Name _____ Home Phone No. _____ Cell Phone No. _____

Is There Video Surveillance of Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Incident Captured on Video? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was ID Scanned Upon Entry? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Not, Was Record Made of ID? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was Any Physical Evidence Recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Describe Evidence		

DESCRIBE INCIDENT (Use Additional Form if Necessary)