LICENSED MENTAL/HEALTH PROVIDER VERIFICATION OF INCIDENT
(INFORMATION REQUESTED WILL BE USED FOR OFFICIAL USE ONLY)
***This form must be included with an NMCVRC online or paper application.**

Please provide victim name and date of birth:

PART I: LICENSED PROVIDER INDENTIFICATION INFORMATION

A. Provider name:

B. License Number:

C. Date the crime was reported to provider:

PART II: CRIME VERIFICATION INFORMATION

A. Reported crime (i.e., domestic violence, sexual assault, etc.):

B. What injuries (physical and/or emotional) were sustained by the victim:

C. Date of crime (on or about):

D. Please provide a brief summary of the incident, as reported to you from the victim/claimant:

E. To the best of your knowledge, did the victim's actions cause, in a substantial way, what happened?1. If yes, please explain:

◯ No ◯ Yes

F. Was the incident reported to a law enforcement agency?:

◯ No ◯ Yes

1. If yes, please list the law enforcement agency:

PART III: AUTHORIZATION INFORMATION

Signature of the person who completed this form:

Print name:

Provider Phone Number or E-mail Address:

Date: