



LICENSED MEDICAL / MENTAL HEALTH / TRIBAL PROVIDER VERIFICATION OF INCIDENT
(INFORMATION REQUESTED WILL BE USED FOR OFFICIAL USE ONLY)

Victim name and date of birth: [Form fields]

PART I: LICENSED PROVIDER IDENTIFICATION INFORMATION

A. Provider name: [Form field]
B. License Number: [Form field]
C. Date the crime was reported: [Form field]

PART II: CRIME VERIFICATION INFORMATION

A. Reported crime (e.g. domestic violence, sexual assault, etc.): [Form field]
B. Date and location of crime (on or about): [Form field]
C. What injuries (physical and/or emotional) were sustained by the victim: [Form field]
D. Please provide a brief, but detailed, summary of the incident as reported to you from the victim/claimant:

[Large empty text box for incident summary]

E. To the best of your knowledge, did the victim's actions cause, in a substantial way what happened?
No Yes, *If yes, please explain (e.g. acting in commission of a crime, gang related, etc.)
[Form field]

F. Was the incident reported to law enforcement? No Yes
If yes, please list the law enforcement agency: [Form field]

PART III: AUTHORIZATION INFORMATION

Signature of the person who completed this form: [Form field]
Print name: [Form field]
Provider Phone Number or Email Address: [Form field]
Date: [Form field]