

INTERNAL AFFAIRS COMPLAINT FORM

Department #:		IA #:			
Name:			Alias:		
Address:					
City:		State:		Zip Code:	
Phone #:					
DOB:		SSN:		Age:	
Sex:		Race:			
Employer/School:				Phone:	
Address:					
City:		State:		Zip Code:	
Phone #:					
INCIDENT					
Nature of Complaint:					
Complaint Against:					
Complaint Against:					
Date:		Time:		Date/Time Reported:	
How Reported:					
Incident Location:					
Description of Incident:					
Description of Any Injuries					
Place of Treatment:			Doctor's Name:		Date of Treatment:
Signature of Complainant:				Date:	
Action Taken:					
<input type="checkbox"/> No Further Action Requested By Complainant: _____ <div style="text-align: right; margin-left: 200px;">Signature of Complainant and Date</div>					
<input type="checkbox"/> Referred to Other Agency: _____ <div style="text-align: right; margin-left: 100px;">Agency Name/Representative</div>					
<input type="checkbox"/> Forwarded to Internal Affairs Unit: _____ <div style="text-align: right; margin-left: 150px;">Date Forwarded</div>					
Employee Taking Complaint:				Date:	