

MARYLAND DOMESTIC VIOLENCE SUPPLEMENTAL REPORT

VICTIM'S NAME (LAST, FIRST, MIDDLE)		DOB:	GENDER:	CASE #
VICTIM'S ADDRESS		PHONE NUMBERS--HOME:	WORK:	HAIR
PERMANENT ALTERNATE CONTACT NAME, ADDRESS & PHONE NUMBER				
VICTIM WILL BE AT TEMPORARY ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO *** If yes, contact state's attorney's office with address and phone number. DO NOT PUT IN THIS REPORT FOR VICTIM SAFETY REASONS***				
I FOUND THE VICTIM WHERE?			DV INFORMATION GIVEN TO VICTIM? <input type="checkbox"/> Y <input type="checkbox"/> N	

VICTIM	WITNESS INFORMATION
MARK ALL THAT APPLY: <input type="checkbox"/> ANGRY <input type="checkbox"/> COMP OF PAIN <input type="checkbox"/> APOLOGETIC <input type="checkbox"/> BRUISE(S) <input type="checkbox"/> CRYING <input type="checkbox"/> ABRASION(S) <input type="checkbox"/> FEARFUL <input type="checkbox"/> MINOR CUT(S) <input type="checkbox"/> HYSTERICAL <input type="checkbox"/> LACERATION(S) <input type="checkbox"/> CALM <input type="checkbox"/> FRACTURE(S) <input type="checkbox"/> AFRAID <input type="checkbox"/> CONCUSSION(S) <input type="checkbox"/> IRRATIONAL <input type="checkbox"/> OTHER: EXPLAIN <input type="checkbox"/> NERVOUS <i>(Always explain</i> <input type="checkbox"/> THREATENING <i>opposites in brief</i> <input type="checkbox"/> OTHER: EXPLAIN <i>narrative on back)</i>	NAME OF WITNESS #1 _____ DATE OF BIRTH _____
	WITNESS ADDRESS _____
	HOME # _____ WORK# _____
	NAME OF WITNESS #2 _____ DATE OF BIRTH _____
	WITNESS ADDRESS _____
	HOME # _____ WORK# _____

SUSPECT	SUSPECT INFORMATION
MARK ALL THAT APPLY: <input type="checkbox"/> ANGRY <input type="checkbox"/> COMP OF PAIN <input type="checkbox"/> APOLOGETIC <input type="checkbox"/> BRUISES <input type="checkbox"/> CRYING <input type="checkbox"/> ABRASION(S) <input type="checkbox"/> FEARFUL <input type="checkbox"/> MINOR CUT(S) <input type="checkbox"/> HYSTERICAL <input type="checkbox"/> LACERATION(S) <input type="checkbox"/> CALM <input type="checkbox"/> FRACTURE(S) <input type="checkbox"/> AFRAID <input type="checkbox"/> CONCUSSION(S) <input type="checkbox"/> IRRATIONAL <input type="checkbox"/> OTHER: EXPLAIN <input type="checkbox"/> NERVOUS <i>(Always explain</i> <input type="checkbox"/> THREATENING <i>opposites in brief</i> <input type="checkbox"/> OTHER: EXPLAIN <i>narrative on back)</i>	NAME OF SUSPECT _____ DATE OF BIRTH _____
	HT _____ WT _____ RACE _____ GENDER _____ HOME# _____ WORK# _____
	ADDRESS OF SUSPECT _____
	IF ARREST WAS MADE: DISTRICT COURT TRACKING NUMBER _____
	CHARGE(S): _____
	_____ MEMBER OF THE MILITARY? <input type="checkbox"/> Y <input type="checkbox"/> N

RELATIONSHIP BETWEEN VICTIM AND SUSPECT

MARK ALL THAT APPLY: <input type="checkbox"/> SPOUSE IF SO, DATE OF MARRIAGE _____ <input type="checkbox"/> FORMER SPOUSE <input type="checkbox"/> COHABITANTS <input type="checkbox"/> FORMER COHABITANTS <input type="checkbox"/> DATING/ENGAGED <input type="checkbox"/> FORMERLY DATING <input type="checkbox"/> SAME SEX <input type="checkbox"/> EMANCIPATED MINOR <input type="checkbox"/> CHILD (OR CHILDREN) IN COMMON LENGTH OF RELATIONSHIP _____ YEAR(S) _____ MONTH(S) IF APPLICABLE, DATE RELATIONSHIP ENDED: _____	PRIOR HISTORY OF DOMESTIC VIOLENCE: <input type="checkbox"/> YES <input type="checkbox"/> NO NUMBER OF PRIOR INCIDENTS _____ VICTIM CONSIDERS THEM TO BE <input type="checkbox"/> MINOR <input type="checkbox"/> SERIOUS REPORTED: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CASE NUMBER(S) _____ PRIOR HISTORY HANDLED BY WHAT POLICE DEPT/AGENCY: _____	ALCOHOL OR DRUGS INVOLVED SUSPECT: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST TYPE(S): _____ VICTIM: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST TYPE(S): _____
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MEDICAL TREATMENT

<input type="checkbox"/> NONE <input type="checkbox"/> WILL SEEK OWN DOCTOR <input type="checkbox"/> FIRST AID GIVEN AT SCENE <input type="checkbox"/> TREATED BY PARAMEDICS <input type="checkbox"/> TRANSPORTED TO HOSPITAL <input type="checkbox"/> MEDICAL AID OFFERED BUT VICTIM REFUSED	PARAMEDICS AT SCENE? <input type="checkbox"/> Y <input type="checkbox"/> N FIRE DEPARTMENT ON SCENE? <input type="checkbox"/> Y <input type="checkbox"/> N UNIT NUMBER(S): _____ EMS EVENT # _____ NAME(S) & ID#(S): _____	HOSPITAL TAKEN TO: _____ ATTENDING MEDICAL PERSONNEL: _____
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PROTECTIVE ORDERS

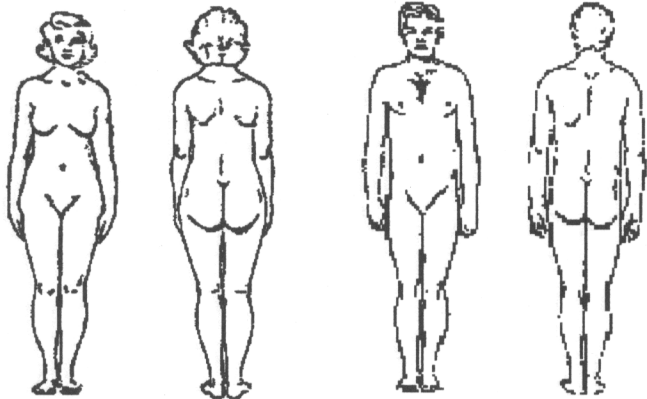
DOES THE VICTIM CURRENTLY HAVE A PROTECTIVE ORDER AGAINST THE SUSPECT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT TYPE? <input type="checkbox"/> EX PARTE ORDER <input type="checkbox"/> PROTECTIVE ORDER
ISSUING COURT _____		EX PARTE/PROTECTIVE ORDER CASE NUMBER _____
IF NO CURRENT ORDER, HAS VICTIM EVER OBTAINED EX PARTE OR PROTECTIVE ORDER AGAINST SUSPECT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT YEAR(S)? _____

CHILD WITNESSES

CHILDREN PRESENT DURING DOMESTIC VIOLENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF CHILDREN PRESENT _____	STATEMENTS TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO
NAMES _____	AGES _____	
_____	_____	
_____	_____	
_____	_____	

OFFICER	ID#	AGENCY	DATE/TIME	APPROVED BY	PAGE 1 OF 2
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EVIDENCE COLLECTED	WEAPONS/ SUSPECT INFORMATION
COLLECTED FROM: <input type="checkbox"/> CRIME SCENE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> OTHER: EXPLAIN PHOTOS: <input type="checkbox"/> YES <input type="checkbox"/> NO NUMBER OF PHOTOS TAKEN: _____ TYPE: <input type="checkbox"/> 35 MM <input type="checkbox"/> POLAROID PHOTOS TAKEN BY: _____ <u>DESCRIBE ALL PHOTOGRAPHS:</u> PHOTO(S) OF VICTIM(S) INJURIES: <input type="checkbox"/> YES <input type="checkbox"/> NO PHOTO(S) OF SUSPECT(S) INJURIES: <input type="checkbox"/> YES <input type="checkbox"/> NO PHOTO(S) OF CRIME SCENE: <input type="checkbox"/> YES <input type="checkbox"/> NO FOLLOW-UP PHOTO(S) OF VICTIM'S INJURIES: <input type="checkbox"/> YES <input type="checkbox"/> NO NUMBER OF HOURS AFTER INCIDENT THAT FOLLOW-UP PHOTOS WERE TAKEN: _____ IS THERE A 911 TAPE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, HAS IT BEEN COLLECTED? <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER EVIDENCE COLLECTED? DESCRIBE: _____ _____ ANY PROPERTY DAMAGE? ESTIMATE VALUE: _____	<u>WEAPONS</u> WEAPON USED DURING INCIDENT: <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE OF WEAPON USED: _____ WEAPON(S) IMPOUNDED: <input type="checkbox"/> YES <input type="checkbox"/> NO FIREARM(S) IMPOUNDED FOR SAFETY: <input type="checkbox"/> YES <input type="checkbox"/> NO <u>SUSPECT INFORMATION</u> CASE STATUS: <input type="checkbox"/> OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> SUSPENDED MIRANDA RIGHTS GIVEN: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE AND TIME GIVEN: _____ DID THE SUSPECT MAKE ANY ADMISSIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(NOTE: RECORD ANY STATEMENTS THE SUSPECT SAYS BELOW UNDER "SUSPECT'S COMMENTS.)</i> ACTION TAKEN: <input type="checkbox"/> ARREST <input type="checkbox"/> NO ARREST IF NO ARREST, GIVE REASON: _____ _____ _____

INJURY DIAGRAM-- TO BE COMPLETED BY THE VICTIM. MARK AND INITIAL IN THE DIAGRAM THE AREA(S) WHERE YOU WERE STRUCK:		VICTIM'S COMMENTS -- VICTIM WRITES STATEMENTS IN THIS SPACE, OR OFFICER RECORDS VICTIM COMMENTS. HAVE VICTIM SIGN BELOW.
HT _____	WT _____ 	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
VICTIM INITIALS _____		VICTIM SIGNATURE _____

I HAVE PHYSICALLY POINTED OUT TO THE OFFICER (TO BE COMPLETED BY VICTIM):	SUSPECT'S COMMENTS -- OFFICERS RECORD ALL ORAL STATEMENTS MADE BY THE SUSPECT.
<p>A. ON THE DIAGRAM WHERE I WAS STRUCK <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<hr/>
<p>B. ON MY PERSON WHERE I WAS STRUCK <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<hr/>
<p>C. THE PERSON WHO STRUCK ME <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>NAME OF PERSON WHO STRUCK ME _____</p>	<hr/>
<p>D. THE OBJECT USED TO STRIKE ME <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<hr/>
<p>I UNDERSTAND ALL THE QUESTIONS <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<hr/>
<p>VICTIM SIGNATURE _____</p>	<hr/>

MEDICAL RELEASE	NARRATIVE -- OFFICERS RECORD THEIR EXPLANATIONS AND COMMENTS HERE; ATTACH ADDITIONAL SHEETS IF NECESSARY
I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT. I HEREBY GRANT RELEASE OF MY MEDICAL RECORDS CONCERNING THIS OR OTHER DOMESTIC VIOLENCE CASES TO LAW ENFORCEMENT AGENCIES/PERSONNEL INVESTIGATING THIS INCIDENT. I ALSO UNDERSTAND THAT A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.	
YO ASEGURO QUE LA INFORMACION QUE HE DADO ES VERDADERO Y CORRECTO. Y POR MEDIO DE LA PRESENTE DOY PERMISO PARA QUE MI HISTORIA MEDICA, CONCERNIENTE A ESTE CASO Y OTROS CASOS DE VIOLENCIA DOMESTICA, SEAN ENTREGADAS A LAS AUTORIDADES DE POLICIA Y A CUALQUIER OTRA ENTIDAD INTERESADA EN INVESTIGAR ESTE CASO. TAMBIEN ENTIENDO QUE UNA COPIA FOTOGRAFICA DE ESTE AUTORIZATION SEA VALIDO COMO EL ORIGNIAL.	
SIGNED _____	
DATE _____	
CASE NUMBER _____	
MARYLAND NETWORK AGAINST DOMESTIC VIOLENCE, COPYRIGHT 1995	PAGE 2 OF 2

Instructions for Domestic Violence Supplemental Report

- ✓ This is a **TWO-PAGE NCR** report form. Fill out **BOTH** pages.
- ✓ These forms are on carbon paper. Either **SEPARATE** the two sets of pages before writing **OR** keep the heavier **BLUE** sheet between them when writing.
- ✓ Write the **CASE NUMBER** on Page Two in the **MEDICAL RELEASE** section.
- ✓ When finished, tear off the **TWO TOP WHITE** copies, staple them together and forward them to the State's Attorney's Office along with your standard **INCIDENT REPORT**.