



Complaint #: (Assigned by IAU)		Type of Complaint		Original to: Internal Affairs Unit/Supervisor Copy to: Complainant at time of complaint Copy to: Division of Police Standards (POST)						
Date of Complaint	Time of Complaint	Day:		How Complaint Was Received	<input type="checkbox"/> In Person <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Telephone <input type="checkbox"/> Other <input type="checkbox"/> Online <input type="checkbox"/> POST(DPS)					
Date of Occurrence	Time of Occurrence	Day:		Location of Incident (#, Street, City)						
Complainant (last, first, M)				Address (#, Street, City, St, & Zip Code)						
Phone: (Home) (Work)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Race	Age	D.O.B.	Married: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Result of: <input type="checkbox"/> Parking Complaint <input type="checkbox"/> Arrest		Traffic Citation <input type="checkbox"/>		Signature of Complainant if Complaint Resolved at Time of Complaint: _____					Date:	
<input type="checkbox"/> Injury		<input type="checkbox"/> Field Interrogation Other ____								
Narrative: 										
(continue on reverse if necessary)										
WARNING: False statements made on this form are punishable under the pains and penalties of perjury. A fine up to \$500 and imprisonment for up to one year shall punish whoever knowingly and intentionally makes a FALSE REPORT of a crime on this form.										
Complainant Should Sign at End of Narrative: _____										
Complainant's Parent or Guardian if Complainant is under (<18) Eighteen: _____										

(1.) Name of Employee Complained Against:				Badge No. / Employee ID No.		POST-C Certification Identification No.				
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> W; <input type="checkbox"/> B <input type="checkbox"/> A; <input type="checkbox"/> M; <input type="checkbox"/> H; <input type="checkbox"/> I: <input type="checkbox"/> O	D.O.B. / Age	Height	Weight	Build	Hair	Eyes			
(2.) Name of Employee Complained Against:				Badge No. / Employee ID No.		POST-C Certification Identification No.				
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> W; <input type="checkbox"/> B <input type="checkbox"/> A; <input type="checkbox"/> M; <input type="checkbox"/> H; <input type="checkbox"/> I: <input type="checkbox"/> O	D.O.B. / Age	Height	Weight	Build	Hair	Eyes			
(1.) Name of Witness:			Address							
Phone	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Age	D.O.B.	Married: <input type="checkbox"/> Yes <input type="checkbox"/> No					
(2) Name of Witness:			Address							
Phone	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Age	D.O.B.	Married: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Signature of Supervisor Receiving Complaint				I.D. No.		Tour of Duty				
Superior Officer Assigned to Investigate Complaint						I.D. No.				
Internal Affairs Unit Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No			Notified by:		Time	Date				