

Type of Incident: \_\_\_\_\_

Was a Weapon Involved:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Were Restraints / Force Used:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was Property Damaged:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Were Chemical Agents or OC Used:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were Arrests Made:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Appr. Unit and/or Law Enf. Agency Notified:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were there Media Inquiries:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Any Injuries / Hospitalizations:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**I.D. #**

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☐ Please check if utilizing the DOC 0435

Date / Time

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