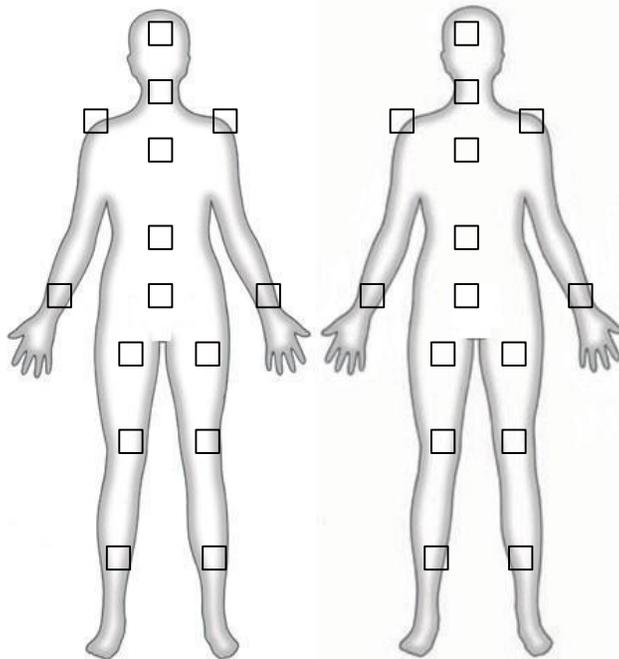


Date of Incident		Time of Incident		INC#	
Address / Location			Type of premises		
Incident occurred: inside <input type="checkbox"/> outside <input type="checkbox"/> open area <input type="checkbox"/> enclosed area <input type="checkbox"/> vehicle <input type="checkbox"/>					
Lighting: Daylight <input type="checkbox"/> Dusk <input type="checkbox"/> Night <input type="checkbox"/> Good artificial <input type="checkbox"/> Poor artificial <input type="checkbox"/>					
Weather condition: Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Rain <input type="checkbox"/> Fog <input type="checkbox"/> snow <input type="checkbox"/>					
Officer's name: Last		First		Middle	
Age		Sex		Race	
Age		Sex		Race	
Subject's name: Last		First		Middle	
Age		Sex		Race	
Age		Sex		Race	
Supervisor notified: yes <input type="checkbox"/> no <input type="checkbox"/> On scene: yes <input type="checkbox"/> no <input type="checkbox"/> IBM#					
Photos taken: yes <input type="checkbox"/> no <input type="checkbox"/> IBM#					
Name(s) of support officers @ scene				On Duty <input type="checkbox"/> Off Duty <input type="checkbox"/>	
				Uniformed <input type="checkbox"/> Non-Uniformed <input type="checkbox"/>	
# of opponents		What weapons did they use?		# of shots fired at officer	
Suspect's Injuries		Not injured <input type="checkbox"/> Superficial <input type="checkbox"/> Critical <input type="checkbox"/> Killed <input type="checkbox"/> Unknown <input type="checkbox"/>			
Officer's Injuries		Not injured <input type="checkbox"/> Superficial <input type="checkbox"/> Critical <input type="checkbox"/> Killed <input type="checkbox"/>			
<b>Type of Force Used</b>					
Firearm <input type="checkbox"/>		Chemical Agent <input type="checkbox"/>		Impact Weapon <input type="checkbox"/>	
				Electronic Control Weapon <input type="checkbox"/>	
				Other <input type="checkbox"/>	
Used a chokehold or similar restraint that may hinder breathing or reduce intake of air? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Conduct that resulted in serious bodily injury? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Conduct that resulted in death? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Did your weapon function properly? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain					
Officer's weapon Make, Model, S/N			Type of ammo used		Number of shots fired
Distance from subject when: First shot was fired			Last shot		
<b>Advanced TASER Use</b>					
Verbal warnings or commands given prior to TASER use: Yes <input type="checkbox"/> No <input type="checkbox"/>					
Advanced TASER probe contact		Yes <input type="checkbox"/> # times applied		No <input type="checkbox"/>	
Touch stun contact		Yes <input type="checkbox"/> # of touch stuns		No <input type="checkbox"/>	
Approximate target distance at the time of dart launch:					
Need for additional dart shot: yes <input type="checkbox"/> no <input type="checkbox"/> Did the dart contacts penetrate the skin: yes <input type="checkbox"/> no <input type="checkbox"/>					
Narrative of circumstances surrounding use of force:					

**FRONT**

**BACK**



<b>Medical Information</b>
Was an Officer, Police Employee or Citizen injured: Yes <input type="checkbox"/> No <input type="checkbox"/>
Nature of injury and medical treatment required other than normal TASER dart impact area:

Officer's Signature	Badge #	Date
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Supervisor's review:	Approved <input type="checkbox"/>	Disapproved <input type="checkbox"/>	Comments attached <input type="checkbox"/>
Signature:			

Command review:	Approved <input type="checkbox"/>	Disapproved <input type="checkbox"/>	Comments attached <input type="checkbox"/>
Signature:			
Chief's review:	Approved <input type="checkbox"/>	Disapproved <input type="checkbox"/>	Comments attached <input type="checkbox"/>
Signature:			

<b>Executive Law 837-T</b>		
NOT Required <input type="checkbox"/>	REQUIRED <input type="checkbox"/>	Completed by