



**SAN FRANCISCO SHERIFF'S OFFICE
STATEMENT OF COMMUNITY MEMBER COMPLAINT
AGAINST AN EMPLOYEE AND/OR OFFICE ACTION**

PRIMARY COMPLAINANT: _____
LAST, FIRST, MIDDLE INITIAL DATE OF BIRTH

CDL# OCCUPATION

HOME OR MAILING ADDRESS: _____
STREET (APT # IF APPLIES)

CITY STATE ZIP PHONE NUMBER WITH AREA CODE

WORK ADDRESS: _____
STREET (APT # IF APPLIES)

CITY STATE ZIP PHONE NUMBER WITH AREA CODE

OPTIONAL INFORMATION TO PROVIDE FOR STATISTICS:

ETHNICITY _____ GENDER IDENTITY _____

INCIDENT INFORMATION:

COMPLAINT AGAINST: _____

NAME/STAR

Date of incident: ____/____/____ Time: ____ Location: _____

Were you injured: YES or NO If yes, please describe your injuries: _____

When did you seek medical attention? Date: ____/____/____

Where did you seek medical attention? Physician: _____

Name of Medical Facility: _____

I am willing to sign a medical records release to assist in the investigation of my complaint. ☐ YES ☐ NO ☐

I have names of witnesses and will provide them to assist in the investigation. ☐ YES ☐ NO ☐

This complaint is against a single member of the San Francisco Sheriff's Office. ☐ YES ☐ NO ☐

This complaint is against more than one member of the San Francisco Sheriff's Office. ☒ YES ☐ NO ☐

COMPLAINANT'S STATEMENT:

[illegible]

DATE _____

Sheriff's employee who received complaint: _____ Star#: _____ Date: _____
 Photos: Y N Recorded interview: Y N Medical records release: Y N Assisted with written statement: Y N
 Complainant was able to identify subjects by name or star number at time of interview: Y N
 Complainant was given a copy of written complaint: Y N