GENERAL INFORMATION									
NAME (LAST, FIRST, M.I.):		AGE:	BIRTH DATE:	HOME #:	WORK/OTHE	R#:	HOME ADDRE	ESS:	
CITY:	STATE:	ZIP CODE	: !	STATE IDENTIFICATION/	DRIVER LICENSE #:		STATE OF ISSUANCE:		
COMPLAINT INFORMATION									
DATE OF INCIDENT:	TIME OF IN	ICIDENT:							
PROVIDE NAMES, BADGE NUMBERS, SQUAD NUMBER OR LICENSE PLATE, and/or PHYSICAL DESCRIPTION OF THE OFFICER AGAINST WHOM YOU WISH TO FILE THE COMPLAINT:									
COMPLAINT:									
WITNESS INFORMATION (Provide contact information for any witnesses you wish to be contacted during the investigation.)									
NAME:			DRESS:	or uny withesses you w	CITY:	STATE:	ZIP:	HOME PHONE #:	
NAME:		AD	DRESS:		CITY:	STATE:	ZIP:	HOME PHONE #:	
NAME:		AD	DRESS:		QTY:	STATE:	ZIP:	HOME PHONE #:	
NAME:		AD	DRESS:		CITY:	STATE:	ZIP:	HOME PHONE #:	
NAME:		AD	DRESS:		CITY:	STATE:	ZIP:	HOME PHONE #:	
				NARRAT	TIVE				
		(F	rovide a full detaile	d account of your com		of the inciden	t)		

PLEASE BE AWARE THAT IF YOU ALLEGE INJURIES AS A RESULT OF THIS INCIDENT, DUE TO FEDERAL PRIVACY LAWS ON THE RELEASE OF MEDICAL RECORDS, YOU MUST									
PROVIDE COPIES OF YOUR RELEVANT MEDICAL RECORDS REGARDING ANY EXAMINATION OR TREATMENT TO THE SHERIFF'S OFFICE INVESTIGATING UNIT TO BE MADE PART OF THE INVESTIGATION.									
COMPLAINANT'S SIGNATURE:	PRINT NAME:	DATE:							
CONFLAMMANT SSIGNATURE.	PRINT NAME:	DATE:							
Please email/mail a completed and signed complaint form to: Email:									
CCSO.OPR@CCSHERIFF.ORG Mail: Office Of Professional Review									
	3026 South California Ave								
Chicago IL, 60608									

(FCN-31)(APR 21)