

HONOLULU COMMUNITY COLLEGE INCIDENT REPORT

- ASSAULT
- HARASSMENT
- PROPERTY DAMAGE/VANDALISM
- MISSING ARTICLE/PROPERTY
- OTHER: Specify _____

Form Submitted to:

- Office of Administrative Services
- Campus Security Office

NAME (last, first, m.i.) of Victim		HOME ADDRESS (no., street, town, state, zip)			
HOME PHONE:		WORK PHONE:			
SOCIAL SECURITY NO.	AGE	SEX: <input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Faculty	<input type="checkbox"/> Volunteer	
			<input type="checkbox"/> Student	<input type="checkbox"/> Other (Please specify):	
			<input type="checkbox"/> Visitor		

Incident facts

Date of occurrence:	Time of occurrence:	Exact location of incident (including room & building number):
Describe incident:		

Composite Description of Suspect

Name (if known):	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Age:	Race:	Hair color:	
Color of eyes:	Height:	Weight:	Build:	Clothing:	Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No
Other identifying marks or features:					

Witnesses (if any)

Name:	Name:
Address:	Address:
Telephone Number:	Telephone Number:

Was the Honolulu Police Department called? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of call:	Time of call:	Name of dispatcher:
HPD Report No. _____			

Medical Data

Was the victim involved examined by a school health nurse? <input type="checkbox"/> Yes (Date & Time of examination: _____) <input type="checkbox"/> No <input type="checkbox"/> No apparent injury	Nature of injury:	If no injury, check box below: <input type="checkbox"/> No Injury
Examination & Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Name of hospital sent to (if sent):	Private physician notified: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Time: _____ Notified by whom: _____

