

Date of Incident		Time of Incident	
Place Incident Occurred			
Allegation(s)			
Source of Allegation(s)			
Subject of Incident's Information:			
Full Name		Title	
Date of Birth		Social Security No.	
Victim (Inmate) Information (If applicable):			
FULL NAME		Title/Reg. No.	
SUMMARY OF INCIDENT : (Provide brief, but complete summation of incident including names of any witnesses)			
Describe any action taken locally prior to OIA referral: Are local, state or federal authorities involved?			
Classification 3 Case ___ Yes ___ No			
Printed Name and Signature of Person Preparing Referral of Incident			
CEO's Printed Name and Signature		Location	Date
NOTE: Please fax all pertinent information as soon as possible after completion of the telephonic referral. Include all statements, memos, affidavits, medical reports, personnel actions as may apply.			

OIA FAX: (202) 514-8625
 FTS 368-8628

Denver Field Office FAX: (303) 365-4445
 Telephone: (303) 365-4400