OFFICE OF THE
STATE'S ATTORNEY
CECIL COUNTY, MARYLAND

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QUESTIONNAIRE

TO THE PERSON OBTAINING CRIMINAL CHARGES, PLEASE READ THIS FORM IN ITS ENTIRETY

- If you have just obtained criminal charges against someone, the attached forms must be completed and returned to our office within two weeks of filling out the application for charges. Please fill out the forms that apply to your case.
- All complainants must fill out the first four (4) pages of the questionnaire and complete the witness summons form, to include names and mailing address of the witnesses.
- Complainants with domestic violence cases must also complete the domestic violence form included in this packet. Please include copies of any active protective orders.
- Victims that have received medical treatment must go to their respective hospital or doctor, sign a release form, and have certified copies of those medical records sent to the Office of the State's Attorney, 129 E. Main Street, Elkton, MD, 21921. If you were seen at Union Hospital, the medical release form is attached. Please complete and sign the release form and include it with this questionnaire.
- Persons wishing to obtain restitution for damaged or stolen property must present estimates or receipts when returning this questionnaire.
- Please contact the office with any questions.

DISTRICT COURT CASE NUMBER:____________________________________

NOTICE TO PERSONS OBTAINING CRIMINAL CHARGES

If you have just obtained criminal charges, the following form MUST be returned to the Office of the State's Attorney within fourteen days of the filing of the charging documents. If the form is returned late or incomplete, please provide an explanation. If the questionnaire is not completed and returned within the fourteen days, the charges could be dismissed.

IMPORTANT NOTICE

FILING OF CRIMINAL CHARGES IS A SERIOUS MATTER. CONSIDERABLE TIME AND TAXPAYER RESOURCES WILL BE SPENT PROCESSING YOUR COMPLAINT. **YOU WILL BE REQUIRED TO APPEAR IN PERSON TO TESTIFY AT TRIAL**.

IF YOU CHANGE YOUR ADDRESS OR PHONE NUMBER AT ANY TIME WHEN THE CASE IS AWAITING TRIAL, PLEASE NOTIFY OUR OFFICE.

INFORMATION TO BE FILLED OUT BY THE PERSON OBTAINING CHARGES:

1. FULL NAME:____________________________________
2. DATE OF BIRTH:____________________________________
3. ADDRESS:____________________________________
4. PHONE NUMBER:____________________________________
5. ALTERNATIVE CONTACT INFO (EMPLOYER, SPOUSE, ETC.):____________
   ____
6. DEFENDANT'S NAME:____________________________________
7. DATE OF INCIDENT:____________________________________
8. DATE CHARGES WERE FILED (IF THERE WAS A DELAY IN FILING CHARGES, PLEASE EXPLAIN):____________________________________
   ____
9. DETAILS OF INCIDENT THAT PROVIDE THE BASIS FOR THE CHARGES:______
   ____
   ____
   ____
   ____
   ____

10. IF A POLICE OFFICER WAS CALLED TO INVESTIGATE OR RESPOND TO THE SCENE, PROVIDE THE OFFICER'S NAME, AGENCY, AND REPORT NUMBER, IF AVAILABLE:______________________________

11. HAS THE PERSON YOU FILED CHARGES AGAINST ALSO FILED CHARGES AGAINST YOU?______________________________

12. DID YOU KNOW THE DEFENDANT PRIOR TO THE TIME OF THE INCIDENT? IF SO, EXPLAIN IN DETAIL HOW YOU KNEW THE PERSON AND ANY PAST PROBLEM(S) YOU MAY HAVE HAD WITH THE PERSON:______________________________

13. HAVE YOU EVER TAKEN OUT CRIMINAL CHARGES AGAINST THE DEFENDANT BEFORE THIS INCIDENT? IF SO, PLEASE PROVIDE THAT INFORMATION WITH DATES, CASE NUMBERS, AND OTHER PERSONS INVOVLED:______________________________

14. WERE ANY PERSONS, INCLUDING YOURSELF, INTOXICATED AT THE TIME OF THE INCIDENT?______________________________

15. DID YOU REQUIRE MEDICAL TREATMENT AS A RESULT OF THE INCIDENT? IF SO, PLEASE PROVIDE THE NAME OF THE HOSPITAL AND DOCTOR:______________________________

16. IF ANY PROPERTY WAS STOLEN OR DAMAGED AS A RESULT OF THIS INCIDENT, PLEASE DESCRIBE THE PROPERTY, ITS VALUE, AND ANY AVAILABLE DOCUMENTATION:____

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17. PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT YOU FEEL IS IMPORTANT TO THE FACTS OF THIS CASE:______________________________

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REQUEST FOR WITNESS SUMMONS

TO THE DISTRICT COURT OFFICE: PLEASE SUMMONS THE FOLLOWING WITNESSES IN THE CASE OF ________________________________ (DEFENDANT), CASE NUMBER D032CR__________________________, AS A STATE'S WITNESS.

NAME: ____

ADDRESS:____

CITY:________________________ STATE:________________ ZIP:___________________

PHONE NUMBER:____________________SECONDARY PHONE:_____________________

NAME: ____

ADDRESS:____

CITY:________________________ STATE:________________ ZIP:___________________

PHONE NUMBER:____________________SECONDARY PHONE:_____________________

NAME: ____

ADDRESS:____

CITY:________________________ STATE:________________ ZIP:___________________

PHONE NUMBER:____________________SECONDARY PHONE:_____________________

NAME: ____

ADDRESS:____

CITY:________________________ STATE:________________ ZIP:___________________

PHONE NUMBER:____________________SECONDARY PHONE:_____________________

NAME: ____

ADDRESS:____

CITY:________________________ STATE:________________ ZIP:___________________

PHONE NUMBER:____________________SECONDARY PHONE:_____________________

REQUESTED BY: (PERSON APPLYING FOR CHARGES)

____

PRINTED NAME AND SIGNATURE DATE

DOMESTIC VIOLENCE QUESTIONNAIRE

VICTIMS/COMPLAINANTS OF DOMESTIC VIOLENCE CASES ARE REQUESTED TO PROVIDE THE INFORMATION REQUESTED BELOW

*ANY CONFIDENTIAL OR IDENTIFYING INFORMATION WILL **NOT** BE DISCLOSED*

VICTIM:____

ADDRESS:____

PHONE NUMBER:____

EMPLOYER, EMPLOYER CONTACT INFORMATION:_______________________

____

____

DEFENDANT'S NAME:____

DEFENDANT'S EMPLOYER:____

NAMES AND AGES OF CHILDREN IN HOUSEHOLD:______________________

____

____

ANY AND ALL INJURIES SUSTAINED IN THIS INCIDENT:___________________

____

____

____

NAME OF DOCTOR/HOSPITAL THAT PROVIDED TREATMENT:_______________

____

____

NAME OF ANY WITNESSES, THEIR ADDRESSES, AND PHONE NUMBERS:________

____

____

____

____

____

DATE AND TIME YOU CALLED 911/POLICE AND WHICH AGENCY (STATE POLICE, SHERIFF'S OFFICE, TOWN POLICE, ETC.):____

____

____

HAVE YOU HAD ANY CONTACT WITH THE DEFENDANT SINCE THE INCIDENT?____

____

____

HAS THE DEFENDANT MADE ANY THREATS OR TRIED TO INTIMIDATE YOU SINCE THE INCIDENT?____

____

____

DO YOU AND THE DEFENDANT LIVE TOGETHER? HAVE YOU EVER LIVED TOGETHER?____

____

____

HAVE YOU EVER APPLIED FOR CRIMINAL CHARGES OR PROTECTIVE ORDERS AGAINST THE DEFENDANT BEFORE?____

____

____

____

WAS THE DEFENDANT USING ALCOHOL OR DRUGS AT THE TIME OF THIS INCIDENT?____

____

____

IS THERE ANYTHING ELSE YOU FEEL WE SHOULD KNOW ABOUT THE DEFENDANT, YOUR RELATIONSHIP, OR THE FACTS OF THIS CASE?_______________

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If you need assistance completing this form, or assistance for victims of domestic violence, please contact the Domestic Violence/Rape Crisis Center at their 24 hour helpline:

(410) 996-0333

Signature: ____ Date: ___________________________

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I, ______________________________________ (name) authorize Union Hospital, 106 Bow Street, Elkton, MD, 21921, to release to the Office of the State's Attorney for Cecil County the following information or medical records (circle all that apply):

Signature:____ Date:____________________

- Admission history and physical
- Discharge summary
- Operative reports
- Pathology reports
- Radiology reports
- Laboratory reports
- Progress notes
- Nursing notes
- Orders
- Consultations
- EKG
- EEG
- Physical therapy
- Occupational therapy
- Respiratory therapy
- Emergency department
- Outpatient surgery
- Records from other hospitals
- Entire record
- Other ____
  ____
  ____
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