The City College of San Francisco

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Sexual Assault on Campus Incident Report

Survivor's Name: ____ Date: ___________
(Please Print Last, First and Middle name)

Address: ____ Home/Cell Phone: ____________

City: ______________________________________ State: ________ Zip: ________ Age: ______

I am a (circle one): Student Staff Faculty Administrator Visitor

Site of the incident: ____
(Campus, building, room or specific location description)

Description of Incident(s), including Date/Time: ____
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____
____
____
____
____

Use and attaché additional sheets if needed.

Faculty, staff, or administrator obtaining the information:

Name: _______________________ Department: _________________ Phone/Cell: ___________
(Print)

Witness (names and contact information): ____
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Sexual Assault is a crime. All City College of San Francisco employees when informed of such occurrence will be available to assist you. To support you most effectively and efficiently we need to inform all appropriate administrators, staff and or offices. For this reason, we will share only the relevant information.

I understand the need to share information about me and this reported incident. I give permission to City College of San Francisco administrators and relevant individuals to share pertinent information regarding the incident reported above on a need-to-know bias to help me through the process.

Signature__________________________ ID#______________________ Date: ______________

Submit this form to: Associate Dean District Public and Student Health Services HC100