

FORM 2

COMPLAINT REPORTING FORM BY MEMBER OF PUBLIC
(Regulation 2(4))

Complaint Details			
CAS/CR No/ Inquest No		Province	
Date of Incident		Time of Incident	
Reported to SAPS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Reported to SAPS	
Name of SAPS station			
Protection Order issued?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Protection Order type	Interim <input type="checkbox"/> Final <input type="checkbox"/>
Date Issued			
Incident relates to : <input type="checkbox"/> Death in police custody <input type="checkbox"/> Death as a result of police action <input type="checkbox"/> Discharge of firearm by police officer <input type="checkbox"/> Rape by police officer On Duty <input type="checkbox"/> Off Duty <input type="checkbox"/> <input type="checkbox"/> Rape of person in police custody <input type="checkbox"/> Torture/assault by police officer <input type="checkbox"/> Corruption within the police			
Complaint description (use additional folios if necessary):			

Complainant Details (Includes third party complaints)			
Role in the case	<input type="checkbox"/> Complainant <input type="checkbox"/> Third Party		
ID Number		Passport Number	
Title		First Name	
Middle Name		Surname	
Landline		Mobile	
Fax		Email	
Nationality		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Disabled status			
Address			
Country		City	
Suburb		Postal Code	
Preferred contact Method (E.g. E-mail, SMS, Post)			
Victim Details			
Passport Number			
First Name		Middle Name	
Surname			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Race	
Age			
Service Member's Details			
Identified	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rank	
Persal Number		ID Number	
Initials			
First Name		Middle Name	
Surname			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Race	
Duty Station		Duty Station Unit	
Identified	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rank	
Persal Number		ID Number	
Initials			
First Name		Middle Name	
Surname			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Race	
Duty Station		Duty Station Unit	
Identified	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rank	
Persal Number		ID Number	

Initials			
First Name		Middle Name	
Surname			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Race	
Duty Station		Duty Station Unit	
Contact Number			
On Duty	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Vehicle Registration Number			
Details of Witnesses to Incident			
Title		First Name	
Middle Name		Surname	
Landline		Mobile	
Title		First Name	
Middle Name		Last Name	
Landline		Mobile	
Title		First Name	
Middle Name		Surname	
Landline		Mobile	
Title		First Name	
Middle Name		Surname	
Landline		Mobile	

COMPLAINANT'S FULL NAMES:

COMPLAINANT'S SIGNATURE:

DATE: