LICENSED MENTAL/HEALTH PROVIDER VERIFICATION OF INCIDENT

(INFORMATION REQUESTED WILL BE USED FOR OFFICIAL USE ONLY)

Return form to: Oregon Crime Victim Compensation cvcportal or cvssd@doj.state.or.us

Victim name and date of birth____

Claim#______________

PART I: LICENSED PROVIDER INDENTIFICATION INFORMATION

A. Provider name: _______________________________

B. License Number: ______________________________

C. Date the crime was reported to provider: _____________________

PART II: CRIME VERIFICATION INFORMATION

A. Reported crime (i.e., domestic violence, sexual assault, etc.):

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B. What injuries (physical and/or emotional) were sustained by the victim:

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C. Date of crime (on or about): ______________________________________

D. Please provide a brief summary of the incident, as reported to you from the victim/claimant:

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E. To the best of your knowledge, did the victim's actions cause, in a substantial way, what happened? ☐No ☐Yes

If yes, please explain:

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F. Was the incident reported to a law enforcement agency? ☐No ☐Yes

If yes, please list the law enforcement agency:

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PART III: AUTHORIZATION INFORMATION

Signature of the person who completed this form: ________________________________

Print name: __________________________

Provider Phone Number or E-mail Address: ____________________________________

Date: _____________