LOST / STOLEN CONTROLLED SUBSTANCE

WITNESS / VICTIM STATEMENT

POST OFFICE BOX 127 • 6438 KOOTENAI STREET • BONNERS FERRY, IDAHO 83805
(208) 267-3151 • FAX (208) 267-3154

DATE: _____ TIME: _____ TYPE OF INCIDENT: _____

NAME: _____ DOB: _____ SOC: _____

ADDRESS (PHYSICAL): _____

PHONE: (H) _____ (W) _____ OTHER: _____

LOCATION OF INCIDENT: _____

HAVE YOU EVER BEEN CONVICTED OF A CHARGE OF POSSESSION OF A CONTROLLED SUBSTANCE? IF YES, WHEN AND WHERE?

_____

_____

_____

HAVE YOU EVER MADE A REPORT OF HAVING A LOST OF STOLEN PRESCRIPTION? IF YES, WHEN, WHERE AND WHAT TYPE OF MEDICATION?

_____

_____

_____

_____

DESCRIBE IN DETAIL HOW YOUR MEDICATION WAS LOST OR STOLEN:

_____

_____

_____

_____

_____

SIGNATURE: _____ **DATE:** _____