

## NON "CT 100" Kit Evidence – Clothing, Bedding and Other Evidence

<b>Victim's Name:</b>			
Victim's DOB:			
Date of Incident:		Date of Evidence Collection:	
Location of Collection:			
<i>Please indicate if collection was from victim, hospital or scene location</i>			

<b>Offender Information</b>			
Number of Males:		Number of Females:	
Relationship of Offenders to Victim: <i>(Please check all that apply)</i>			
<input type="checkbox"/>	Stranger	<input type="checkbox"/>	Family Member
<input type="checkbox"/>		<input type="checkbox"/>	Caregiver
<input type="checkbox"/>		<input type="checkbox"/>	Cohabitant same household
<input type="checkbox"/>	Other:		

Contact by Offender to:	Contact by Hand	Contact by Mouth/Oral	Contact by Penis
Victim's Clothing:			
Victim's Body:			
Other:			
Ejaculation by Offender on: <i>If possible, please indicate location (ex. side of bedding) of ejaculation</i>			
Victim's Clothing:		Location:	
Victim's Body:		Location:	
Bedding/Other:		Location:	
Was Condom Used?:		If Yes, Number of Offenders that used condoms:	
Was Victim Injured and bleeding?		Location:	
Was Suspect injured and bleeding?		Location:	
Was Victim menstruating at time of assault?			
Was the collected clothing worn after OTHER sexual activity?		If yes, type of OTHER sexual activity:	
If bedding collected, has OTHER sexual activity occurred on bedding?		If yes, type of OTHER sexual activity:	
After the Sexual Assault, was the evidence laundered?		If yes, indicate article of clothing/bedding washed:	

Completed by:		Date:	
Agency:		Agency Case Number:	
Contact Phone:		Email:	

*Please attach additional pages if needed to provide other information that was not captured in the form.*