

CONSENT FOR RECEIPT OF EVIDENCE

Upon receipt of evidence, fill out necessary information below

*** Store clothing and other items in paper bag only (not plastic)**

DATE: _____

RECEIVED FROM: _____

MEDICAL FACILITY: _____

- PHOTOGRAPHS OF OR ITEMS FROM:

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

- ITEMS (LIST) _____

SIGNATURES:

1. PATIENT OR CLIENT _____ DATE _____

2. MEDICAL PROVIDER WITH TITLE (PRINT) _____

SIGNATURE _____ DATE _____

3. POLICE OFFICER (PRINT) _____ DEPT. BADGE # _____

SIGNATURE _____ DATE _____

4. PROSECUTOR'S OFFICE (PRINT NAME) _____ TITLE _____

SIGNATURE _____ DATE _____

LOCATION OF ITEMS:

- ITEMS STORED ON SITE: _____
(LOCATION)

- ITEMS TRANSPORTED TO: _____
(LOCATION)