

RESOLUTION NO. 4029

**A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF SOLEDAD
APPROVING AND AUTHORIZING THE CITY MANAGER TO EXECUTE
A CONTRACT WITH THE MONTEREY COUNTY HEALTH DEPARTMENT FOR
SEXUAL ASSAULT RESPONSE TEAM (SART) SERVICES**

WHEREAS, City has an immediate need to contract for the provision of sexual assault examiner services; and

WHEREAS, City previously contracted with Visiting Nurses Association for sexual assault examiner services; and

WHEREAS, the Monterey County Health Department has indicated its willingness to provide City with the desired services at a 20% cost increase over FY2006-07; and

WHEREAS, City has performed an expedited survey of available service providers, and has determined that the Monterey County Health Department's Sexual Assault Response Team (SART) is the only available resource available to the City of Soledad and offers the desired quality services at an acceptable cost.

NOW THEREFORE, BE IT HEREBY RESOLVED by the City Council of the City of Soledad that the "Sexual Assault Response Team" services between the City and the Monterey County Health Department, a copy of which is attached hereto as Exhibit "A" and by this reference incorporated herein, is hereby approved, and the City Manager is hereby authorized and directed to execute the same on behalf of the City of Soledad.

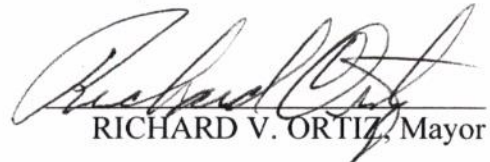
PASSED AND ADOPTED by the City Council of the City of Soledad at a regular meeting duly held on the 20th day of June 2007, by the following vote:

AYES, and in favor thereof, Councilmembers: Martha Camacho, Juan Saavedra, Pat Stephens, Mayor Richard Ortiz

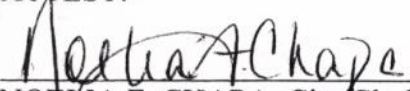
NOES, Councilmembers: None

ABSTAIN, Councilmembers: None

ABSENT, Councilmember: Mayor Pro Tem Christopher Bourke


RICHARD V. ORTIZ, Mayor

ATTEST:


NOELIA F. CHAPA, City Clerk

**Agreement Between
LAW ENFORCEMENT AGENCY
And
Monterey County Health Department
For Sexual Assault Examiner Services**

THIS AGREEMENT is made and entered into as of the date set forth herein below, by and between City of Soledad (hereinafter "AGENCY") and the Monterey County Health Department (hereinafter "COUNTY"). The purpose of this Agreement is to contract for administrative and related services of a Sexual Assault Response Team, hereinafter, SART.

RECITALS

1. AGENCY has the ability to eliminate repetitive or unnecessary questioning and to ensure correct and accurate collection of evidence; and,
2. COUNTY desires to improve the quality of the evidence gathering process of a sexual assault to increase the conviction rate of sexual assault perpetrators, and at the same time, remain sensitive to the needs of sexual assault victims; and to ensure that all sexual assault survivors and suspects receive an immediate and comprehensive medical-legal examination; and to implement a coordinated effort between SART and Law Enforcement agencies to assist the criminal justice system in the proper collection of evidence, interpretation of findings, and presentation of expert opinion; and
3. AGENCY and COUNTY agree that it is more practical and effective to implement some of the goals of a successful sexual assault response system by way of this Agreement; and,
4. AGENCY and COUNTY desire to ensure the continuation of a prompt, organized, and effective team response to cases of adult, adolescent, and acute pediatric sexual assault in Monterey County throughout the continuity of the SART Program.

NOW, THEREFORE, in consideration of the covenants, conditions, stipulations, and terms hereinafter expressed, AGENCY and COUNTY agree as follows:

5. COUNTY Performance Obligations

The SART Program Coordinator shall represent COUNTY and SART in all matters pertaining to this Agreement, and shall administer this Agreement on behalf of COUNTY. The Chief of Police/Warden/Sheriff or his/her designee shall represent AGENCY in all matters pertaining to services rendered pursuant to this Agreement, and shall administer this Agreement on behalf of AGENCY.

Exhibit A

6. Independent Contractors

AGENCY shall not have or exercise any control or direction over the methods by which COUNTY shall perform its work and functions under this Agreement. The sole interest of AGENCY is to assure that the contractual duties and obligations are carried out in a competent, efficient, and satisfactory manner.

7. Mutual Hold Harmless

- (a) COUNTY shall hold harmless and indemnify AGENCY against any and all claims, demands, suits, judgments, expenses and costs of any kind, insofar as it may legally do so, on account of the injury to or death of persons or loss of property arising in any manner out of the COUNTY'S performance of this Agreement.
- (b) AGENCY shall hold harmless and indemnify COUNTY against any and all claims, demands, suits, judgments, expenses, and costs of any and every kind, insofar as it may legally do so, on account of the injury to or death of persons or loss of property arising in any manner out of the AGENCY'S performance of this Agreement.
- (b) It is the intention of COUNTY and AGENCY that the provision of this paragraph be interpreted to impose on each party responsibility for the negligent and/or intentional acts of its officers, agents, and employees.

8. Conflict of Interest

COUNTY agrees that all reasonable efforts will be taken to ensure that no conflict of interest exists for its officers, agents or employees in connection with the performance of this Agreement. COUNTY shall use its best efforts to prevent employees, consultants, subcontractor(s) or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain either for themselves or others, such as those with whom they have family, business, or other ties.

9. Confidentiality of Client Records

COUNTY, its officers, employees, agents and subcontractors shall protect from unauthorized disclosure, the names and/or other identifying information concerning both persons receiving services or assistance under this Agreement, as well as persons whose names or other identifying information become known to SART as a result of services performed under this Agreement, except for statistical information which does not identify any such person(s). COUNTY, its officers, employees, agents and subcontractors shall not use information that identifies any individual receiving services under this Agreement for any purpose other than carrying out COUNTY's obligations under this Agreement.

- (a) AGENCY, its officers, employees, agents and subcontractors shall

promptly inform SART of any and all requests, whether written or oral, for disclosure of such identifying information as is described in this section.

- (b) AGENCY shall not disclose, except as authorized or required by applicable law, any identifying information.
- (c) For purposes of this section, the term "identifying information" shall include, but not be limited to name, identifying number, symbol or other identifying particular(s) assigned to the individual, such as finger or voice print or photographs.
- (d) AGENCY shall impose similar confidentiality requirements upon any contracts or subcontracts for services under this Agreement.

10. Adherence to Examination Protocols

AGENCY agrees to adhere to the patient examination protocol, which is as follows:

- (a) AGENCY shall require that its peace officers and employees offer each sexual assault victim a patient examination if the victim is in contact with the AGENCY within seventy-two (72) hours of the time of assault.
- (b) AGENCY shall ensure prompt transport of the victim to the nearest SART unit either by offering transportation or by ensuring transportation will be provided in a private vehicle.
- (c) AGENCY agrees to have the responding officer contact the Sexual Assault Forensic Examiner via Monterey County Communications prior to transporting the sexual assault victim to the SART unit. This will ensure the appropriate individuals will be contacted. Sexual assault examinations will not be provided until this occurs.
- (d) If the sexual assault victim appears in any hospital emergency room in Monterey County, AGENCY shall have the responding officer promptly contact SART via Monterey County Communications as previously stated.
- (e) AGENCY shall sign the following forms for all victim and/or voluntary suspect examinations either in person, by fax, or by telephone authorization.
 - Authorization for Examination, OES 923, 930, or 950 (Exhibit A)
 - Evidentiary Exam Invoice (Exhibit B)
- (f) Upon completion of the examination, AGENCY shall have the

responding officer transport the physical evidence kit to the Law Enforcement Agency's Evidence Room.

- (g) All medical records, photography, films and digital images shall remain at the PROVIDER'S office. Copies may be requested from the SART Coordinator.

11. Billing, Collection and Reimbursement

The parties acknowledge that current law prohibits the victim of sexual assault from being held financially responsible for the cost incurred in the provision of an examination for the purpose of gathering evidence for possible prosecution. COUNTY agrees to establish a system for billing such services.

- (a) COUNTY agrees to bill the appropriate AGENCY for charges associated with the sexual assault examinations. COUNTY and AGENCY agree that all billing and payment/collection transactions under this Agreement shall be in accordance with the rates set forth in Exhibit "B" to this Agreement, which is attached hereto and is incorporated herein by this reference.
- (b) COUNTY shall be reimbursed by the AGENCY not later than thirty (30) days after COUNTY submits the invoice. COUNTY shall submit invoices in conformance with Exhibit B, "Invoice", which is attached to this Agreement and by this reference is incorporated herein and made a part hereof.
- (c) The signed original and one copy of each invoice shall be submitted to AGENCY address as indicated in Section 16 below. A copy shall also be maintained in the SART Coordinator's office.
- (d) Each invoice shall be submitted under the letterhead of COUNTY and shall contain:
- Names and titles of all subcontractors for which reimbursement is requested for the invoice period.
 - Actual expenses incurred according to the approved rate; and
 - The original signature of an authorized official of SART.
- (e) Monthly invoices will be submitted no later than forty-five (45) working days after the end of the invoice period.
- (f) The fees for sexual assault examinations shall not be subject to re-negotiation during the term of this Agreement.

12. Term

This Agreement shall commence on July 1, 2007, and shall continue in full force and effect until June 30, 2008. This Agreement may be terminated without cause by either party upon thirty (30) days' prior written notice to the other party.

13. Entire Agreement

This Agreement supersedes any and all other agreements, whether oral or written, between the parties with respect to the subject matter of the Agreement, and no other agreement, statement, or promise relating to the subject matter of the agreement, which is not contained herein, shall be valid or binding.

14. Execution

This Agreement shall be deemed duly executed and binding upon execution by COUNTY and AGENCY.

15. Amendment

The parties to this Agreement may alter, amend, or modify it at any time. However, no alteration, amendment, or modification of the terms of this Agreement shall be valid unless executed by written amendment hereto and approved by both the COUNTY and AGENCY.

16. Notices

Notices to the parties in connection with this contract shall be given personally or by United States Mail, addressed as follows:

COUNTY

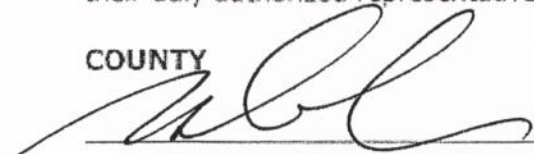
Monterey County Health Department
Sexual Abuse Services Team (SART)
1270 Natividad Road
Salinas, CA 93906-3198
Attention: SART Coordinator

AGENCY

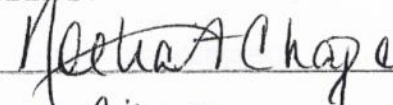
City of Soledad
248 Main Street
P. O. Box 156
Soledad, CA 93960
Attention: Noelia F. Chapa/City
Manager

IN WITNESS WHEREOF, the parties hereto caused this Agreement to be executed by their duly authorized representatives on the dates set forth hereinbelow.

COUNTY


Title Director of Health
Date 8-3-07

AGENCY


Title City manager
Date July 24, 07

APPROVED AS TO FORM
W. Allen Bidwell 05-15-07
COUNTY COUNSEL
MONTEREY

EXHIBIT B

SEXUAL ASSAULT RESPONSE TEAM
EVIDENTIARY EXAM INVOICE

DATE: _____ CASE NUMBER _____

PATIENT MRN _____ DOB _____ AGE _____

JURISDICTION _____ OFFICER _____

EXAMINER _____ TIME IN _____ TIME OUT _____

EXAMINATION INFORMATION	CHECK ALL THAT APPLY	CHARGE
Victim Exam SART Program Service Charge		\$600.00
Suspect Exam SART Program Service Charge		\$600.00
Photography		\$25.00
Testimony/Prep	Number of hours:	@ \$50.00/hr
Cancelled Exam		\$125.00
Other		
		Total Charge:

AGENCY BILLING ADDRESS:

Agency Name _____

Street _____ City _____ Zip _____

Signature of Authorizing Party _____ Date _____

Signature of Examiner _____ Date _____

Signature of Coordinator _____ Date _____

**FORENSIC MEDICAL REPORT: ACUTE (<72 HOURS)
ADULT/ADOLESCENT SEXUAL ASSAULT EXAMINATION**

STATE OF CALIFORNIA
GOVERNOR'S OFFICE of EMERGENCY SERVICES

OES 923

Confidential Document

Patient Identification

A. GENERAL INFORMATION (print or type)

Name of Medical Facility:

1. Name of patient		Patient ID number			
2. Address	City	County	State	Telephone (W) (H)	
3. Age	DOB	Gender M F	Ethnicity	Date/time of arrival	Date/time of discharge

B. REPORTING AND AUTHORIZATION

Jurisdiction (city county other):

1. Telephone report made to law enforcement agency		ID Number		Telephone	Reported by:	Date	Time
Name of Officer	Agency				Name		
2. Responding Officer		ID Number		Telephone			
Agency							

3. I request a forensic medical examination for suspected sexual assault at public expense.

Telephone Authorization Agency: Authorizing party: <hr/> ID number: Datetime:	Law enforcement officer	ID number	Agency	
	Telephone	Date	Time	Case Number

C. PATIENT INFORMATION

- I understand that hospitals and health care professionals are required by Penal Code Sections 11160-11161 to report to law enforcement authorities cases in which medical care is sought when injuries have been inflicted upon any person in violation of any state penal law. The report must state the name of the injured person, current whereabouts, and the type and extent of injuries. _____ (Initial)
- I have been informed that victims of crime are eligible to submit crime victim compensation claims to the State Victims of Crime (VOC) Restitution Fund for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining and rehabilitation. _____ (Initial)

D. PATIENT CONSENT

Minors: Family Code Section 6927 permits minors (12 to 17 years of age) to consent to medical examination, treatment, and evidence collection for sexual assault without parental consent. See instructions for parental notification requirements for minors.

- I understand that a forensic medical examination for evidence of sexual assault at public expense can, with my consent, be conducted by a health care professional to discover and preserve evidence of the assault. If conducted, the report of the examination and any evidence obtained will be released to law enforcement authorities. I understand that the examination may include the collection of reference specimens at the time of the examination or at a later date. I understand that I may withdraw consent at any time for any portion of the examination. _____ (Initial)
- I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area. _____ (Initial)
- I hereby consent to a forensic medical examination for evidence of sexual assault. _____ (Initial)
- I understand that data without patient identity may be collected from this report for health and forensic purposes and provided to health authorities and other qualified persons with a valid educational or scientific interest for demographic and/or epidemiological studies. _____ (Initial)

Signature _____ Patient Parent Guardian

DISTRIBUTION OF OES 923

- Original - Law Enforcement Copy within evidence kit - Crime Lab Copy - Child Protective Services Copy - Medical Facility Records (if patient is a minor)

E. PATIENT HISTORY

1. Name of person providing history: _____ Relationship to patient: _____

2. Pertinent medical history:

- Last menstrual period _____
- Any recent (60 days) anal-/genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings? No Yes
If yes, describe: _____
- Any other pertinent medical condition(s) that may affect the interpretation of current physical findings? No Yes
If yes, describe: _____
- Any pre-existing physical injuries? No Yes
If yes, describe: _____

3. Pertinent pre- and post-assault related history:

- Other intercourse within past 5 days?

	No	Yes	Unsure
if yes,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anal (within past 5 days)?	When _____	<input type="checkbox"/>	<input type="checkbox"/>
vaginal (within past 5 days)?	When _____	<input type="checkbox"/>	<input type="checkbox"/>
oral (within past 24 hours)?	When _____	<input type="checkbox"/>	<input type="checkbox"/>
if yes, did ejaculation occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
if yes, where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
if yes, was a condom used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 - Any voluntary alcohol use within 12 hours prior to assault? No Yes
 - Any voluntary drug use within 96 hours prior to assault? No Yes
 - Any voluntary drug or alcohol use between the time of the assault and the forensic exam? No Yes
- *If yes, collection of toxicology samples is recommended according to local policy. Blood Urine

4. Post-assault hygiene/activity: Not applicable if over 72 hours

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Urinated | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Defecated | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital or body wipes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, describe: _____ | | | | |
| Douched | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, with what _____ | | | | |
| Removed/inserted tampon <input type="checkbox"/> diaphragm <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral gargle/rinse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bath/shower/wash | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brushed teeth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ate or drank | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Changed clothing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, describe: _____ | | | | |

5. Assault-related history:

- Loss of memory? If yes, describe: No Yes
- Lapse of consciousness? If yes, describe: No Yes
- *If yes, collection of toxicology samples is recommended according to local policy. Blood Urine
- Vomited? If yes, describe: No Yes
- Non-genital injury, pain and/or bleeding? If yes, describe: No Yes
- Anal-genital injury, pain, and/or bleeding? If yes, describe: No Yes

F. ASSAULT HISTORY

1. Date of assault(s): _____ Patient identification of assault(s): _____

2. Pertinent physical surroundings of assault(s): _____

3. Alleged assailant(s) name(s)	Age	Gender	Ethnicity	Relationship to patient	
				Known	Unknown
#1		M F			
#2		M F			
#3		M F			
#4		M F			

4. Methods employed by assailant(s):

- | | | | |
|---------------------------------|--------------------------|--------------------------|-------------------|
| | No | Yes | If yes, describe: |
| Weapons | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Threatened? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Injuries inflicted? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Type(s) of weapons? | | | _____ |
| Physical blows | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Grabbing/holding/pinching | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Physical restraints | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Choking/strangulation | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Burns (thermal and/or chemical) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Threat(s) of harm | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Target(s) of threat(s) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other methods | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

- Involuntary ingestion of alcohol/drugs: No Yes Unsure
- If yes, Alcohol Drugs
- If yes, Forced Coerced Suspected
- If yes, toxicology samples collected: Blood Urine None

5. Injuries inflicted upon the assailant(s) during assault? No Yes

If yes, describe injuries, possible locations on the body, and how they were inflicted: _____

G. ACTS DESCRIBED BY PATIENT

- Any penetration of the genital or anal opening, however slight, constitutes the act.
- Oral copulation requires only contact
- If more than one assailant, identify by number.

Patient Identification

1. Penetration of vagina by:					Describe
	No	Yes	Attempted	Unsure	
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, describe the object:					
2. Penetration of anus by:					Describe
	No	Yes	Attempted	Unsure	
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, describe the object:					
3. Oral copulation of genitals:					Describe:
	No	Yes	Attempted	Unsure	
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Oral copulation of anus:					Describe:
	No	Yes	Attempted	Unsure	
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Non-genital act(s):					Describe:
Licking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kissing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suction injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Other act(s):					Describe:
	No	Yes	Attempted	Unsure	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Did ejaculation occur?					Describe
	No	Yes		Unsure	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
If yes, note location(s):					
<input type="checkbox"/> Mouth					
<input type="checkbox"/> Vagina					
<input type="checkbox"/> Anus/Rectum					
<input type="checkbox"/> Body surface					
<input type="checkbox"/> On clothing					
<input type="checkbox"/> On bedding					
<input type="checkbox"/> Other					
8. Contraceptive or lubricant products:					Describe type/brand, if known:
	No	Yes		Unsure	
Foam used?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Jelly used?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Lubricant used?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Condom used?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

G. ACTS DESCRIBED BY PATIENT

- Any penetration of the genital or anal opening, however slight, constitutes the act.
- Oral copulation requires only contact
- If more than one assailant, identify by number.

Patient Identification

1. Penetration of vagina by:

	No	Yes	Attempted	Unsure	Describe
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If yes, describe the object: _____

2. Penetration of anus by:

	No	Yes	Attempted	Unsure	Describe
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If yes, describe the object: _____

3. Oral copulation of genitals:

	No	Yes	Attempted	Unsure	Describe
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. Oral copulation of anus:

	No	Yes	Attempted	Unsure	Describe
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5. Non-genital act(s):

	No	Yes	Attempted	Unsure	Describe
Licking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kissing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suction injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

6. Other act(s):

	No	Yes	Attempted	Unsure	Describe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

7. Did ejaculation occur?

	No	Yes	Unsure	Describe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

If yes, note location(s):

- Mouth
- Vagina
- Anus/Rectum
- Body surface
- On clothing
- On bedding
- Other

8. Contraceptive or lubricant products:

	No	Yes	Unsure	Describe type/brand, if known:
Foam used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jelly used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lubricant used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Condom used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

H. GENERAL PHYSICAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Blood Pressure	Pulse	Resp	Temp	2. Date/time examination	
				Started	Completed
3. Describe general physical appearance				4. Describe general demeanor	

Patient Identification

5. Describe condition of clothing upon arrival.

6. Collect outer and underclothing if indicated. Not indicated
7. Conduct a physical examination. Findings No Findings
8. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with a Wood's Lamp. Findings No Findings
9. Collect fingernail scrapings or cuttings according to local policy.

Diagram A

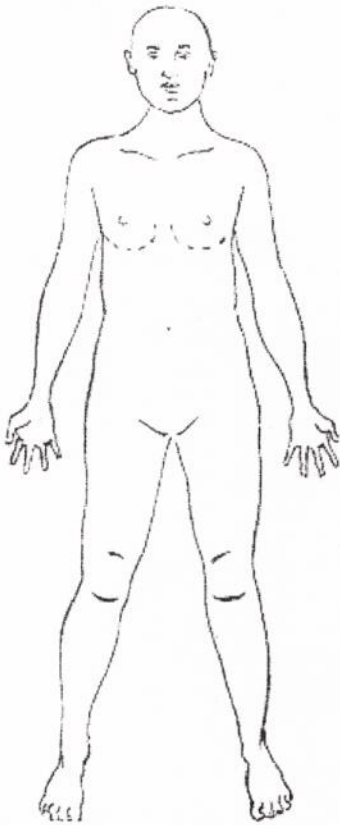
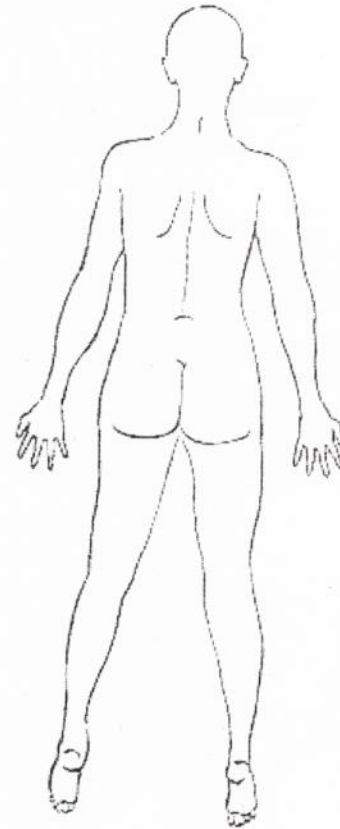


Diagram B



LEGEND: Types of Findings

AB Abrasion	DF Deformity	FB Foreign Body	MS Moist Secretion	PE Petechiae	TB Toluidine Blue B
BI Bite	DS Dry Secretion	IN Induration	OF Other Foreign	PS Potentia Saliva	TE Tenderness
BU Burn	EC Ecchymosis (bruise)	IW Incised Wound	Materna's (describe)	SHX Sample Per History	VIS Vegetation/Soil
CS Control Swab	ER Erythema (redness)	LA Laceration	OI Other Injury (describe)	SI Suction Injury	WL Wood's Lamp B
DE Debris	F/H Fiber/Hair		SW Swelling		

Locator #	Type	Description	Locator #	Type	Description

RECORD ALL CLOTHING AND SPECIMENS COLLECTED ON PAGE 8

1. HEAD, NECK, AND ORAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Examine the face, head, hair, scalp, and neck for injury and foreign materials. Findings No Findings
2. Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, scalp, and neck. Findings No Findings
3. Examine the oral cavity for injury and foreign materials (if indicated by assault history). Collect foreign materials.
Exam done: Not applicable Yes Findings No Findings
4. Collect 2 swabs from the oral cavity up to 12 hours post assault and

Diagram C



Diagram D



Diagram E

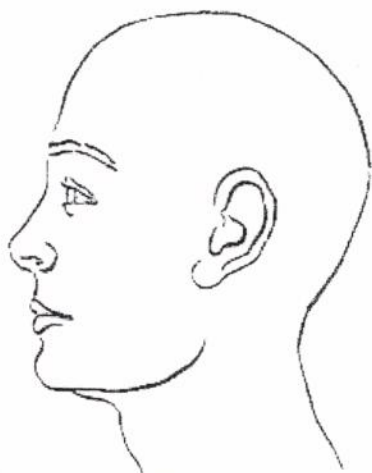


Diagram F



LEGEND: Types of Findings

AB Abrasion	DF Deformity	FB Foreign Body	MS Moist Secretion	PE Petechiae	TB Toluidine Blue [®]
BI Bite	DS Dry Secretion	IN Induration	OF Other Foreign	PS Potential Saliva	TE Tenderness
BU Burn	EC Ecchymosis (bruise)	IW Incised Wound	MA Material (describe)	SHX Sample Per History	V/S Vegetation Swab
CS Control Swab	ER Erythema (redness)	LA Laceration	OI Other Injury (describe)	SI Suction Injury	WL Wood's Lamp [®]
DE Debris	F/H Fiber/Hair		SW Swelling		

Locator #	Type	Description	Locator #	Type	Description

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

L. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing placed in evidence kit Other clothing placed in bags

Patient Identification

2. Foreign materials collected

	No	Yes	Collected by:
Swabs/suspected blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dried secretions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose hairs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vegetation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soil/debris	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected semen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected saliva	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/Wood's Lamp® area(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Control swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fingernail scrapings/cuttings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Matted hair cuttings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pubic hair combings/brushings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Intravaginal foreign body	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, describe: _____			
Other types	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, describe _____			

3. Oral/genital/anal/rectal samples

	# Swabs	# Slides	Time collected	Collected by:
Oral				
Vaginal				
Cervical				
Anal				
Rectal				
Penile				
Scrotal				
Aspirate/washings (optional)	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

4. Vaginal wet mount slide

	No	Yes	Time	Examiner:
Slide prepared	<input type="checkbox"/>	<input type="checkbox"/>		
Motile sperm observed	<input type="checkbox"/>	<input type="checkbox"/>		
Non-motile sperm observed	<input type="checkbox"/>	<input type="checkbox"/>		

M. TOXICOLOGY SAMPLES

	No	Yes	Time	Collected by:
Blood alcohol/toxicology (gray top tube)	<input type="checkbox"/>	<input type="checkbox"/>		
Urine toxicology	<input type="checkbox"/>	<input type="checkbox"/>		

N. REFERENCE SAMPLES

	No	Yes	Collected by:
Blood (lavender top tube)	<input type="checkbox"/>	<input type="checkbox"/>	
Blood (yellow top tube)	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Card (optional)	<input type="checkbox"/>	<input type="checkbox"/>	
Buccal swabs (optional)	<input type="checkbox"/>	<input type="checkbox"/>	
Saliva swabs	<input type="checkbox"/>	<input type="checkbox"/>	
Head hair	<input type="checkbox"/>	<input type="checkbox"/>	
Pubic hair	<input type="checkbox"/>	<input type="checkbox"/>	

O. PHOTO DOCUMENTATION METHODS

	No	Yes	Colposcope/ 35mm	Macrolens/ 36mm	Colposcope/ Videocamera	Other Optics
Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Photographed by: _____						

P. RECORD EXAM METHODS

	No	Yes	No	Yes
Direct visualization only	<input type="checkbox"/>	<input type="checkbox"/>	Iodine Blue Dye	<input type="checkbox"/>
Colposcopy	<input type="checkbox"/>	<input type="checkbox"/>	Anoscopy exam	<input type="checkbox"/>
Other magnifier	<input type="checkbox"/>	<input type="checkbox"/>	Anal speculum exam	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, describe _____				

Q. RECORD EXAM FINDINGS

Physical Findings No Physical Findings

R. RECORD ASSESSMENT OF FINDINGS

Exam consistent with history
 Exam inconsistent with history

S. SUMMARIZE FINDINGS

T. PRINT NAMES OF PERSONNEL INVOLVED

History taken by: _____ Telephone: _____

Exam performed by: _____

Specimens labeled and sealed by: _____

Assisted by: N/A

Signature of examiner _____ License No _____

U. EVIDENCE DISTRIBUTION GIVEN TO:

Clothing (item(s) not placed in evidence kit) _____
 Evidence Kit _____
 Reference blood samples _____
 Toxicology samples _____

V. SIGNATURE OF OFFICER RECEIVING EVIDENCE

Signature: _____
 Print name and ID #: _____
 Agency: _____
 Date: _____ Phone: _____