



Conducted Electrical Weapon Reporting Form

To be completed by any Vermont Law Enforcement Officer after the display or deployment of a Conducted Electrical Weapon (CEW)

SECTION ONE: Display and/or Deployment Information

| | | | |
|---|---|---|-----------------------|
| Case Number: | 17SA002144 | Location of Incident: | LaQuinta - Fairfax Rd |
| Date of Incident: | 3-21-17 3-19-17 | Time of Incident: | 1548 |
| CEW Model: | X26 | CEW Serial Number: | X00-649738 |
| Use of CEW: Check all that apply | <input checked="" type="checkbox"/> CEW displayed | | |
| | <input type="checkbox"/> Probes fired | Location where probes hit subject: | |
| | <input type="checkbox"/> Drive stun mode | No. of cycles: | |
| | | Location where was CEW held against subject's body: | |
| Was a recording device running at the time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was it a <input checked="" type="checkbox"/> Body Cam <input type="checkbox"/> Dashboard Cam <input type="checkbox"/> other (describe): | | | |
| Was the subject: <input type="checkbox"/> Human OR <input checked="" type="checkbox"/> Animal (if animal, STOP here and submit form) | | | |
| Was subject charged with a crime? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what charge(s): | | | |

SECTION TWO: Incident Information

| | | | | | | | | | | | | | | | | |
|--|--|---|---|---|---|--|---|--|--|--|-------------------------------------|---|--|---|--|--|
| 1. Subject Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male | 2. Subject Age (if unknown, give an approximate guess): | 3. Perceived race of subject at the time of display or deployment: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African-American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 4. Before deployment, did you have reason to believe the subject was a member of a special population? If yes, check all that apply. (If none apply, go to Question 6) | | | | | | | | | | | | | | | | |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Pregnant</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Traumatic Brain Injury</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Elderly (Over the age of 55)</td> <td style="border: none;"><input type="checkbox"/> Emotional crisis to the extent subject may have had difficulty understanding requests or orders</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Child (Under the age of 16)</td> <td style="border: none;"><input type="checkbox"/> Epilepsy/seizure disorder</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Low body-mass index (Body type is Thin)</td> <td style="border: none;"><input type="checkbox"/> Heart condition</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Disability</td> <td style="border: none;"><input type="checkbox"/> Deaf/hard of hearing</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Mental health condition</td> <td style="border: none;"><input type="checkbox"/> Low vision/blind</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Developmental/intellectual disability</td> <td></td> </tr> </table> | | | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Elderly (Over the age of 55) | <input type="checkbox"/> Emotional crisis to the extent subject may have had difficulty understanding requests or orders | <input type="checkbox"/> Child (Under the age of 16) | <input type="checkbox"/> Epilepsy/seizure disorder | <input type="checkbox"/> Low body-mass index (Body type is Thin) | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Disability | <input type="checkbox"/> Deaf/hard of hearing | <input type="checkbox"/> Mental health condition | <input type="checkbox"/> Low vision/blind | <input type="checkbox"/> Developmental/intellectual disability | |
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| <input type="checkbox"/> Mental health condition | <input type="checkbox"/> Low vision/blind | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Developmental/intellectual disability | | | | | | | | | | | | | | | | |
| 5. How did you obtain information leading to your belief that the subject was a member of a special population? Check all that apply: | | | | | | | | | | | | | | | | |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Subject notified officer</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Civilian witness</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Professional witness</td> <td style="border: none;"><input type="checkbox"/> Dispatch</td> </tr> <tr> <td colspan="2" style="border: none;"><input type="checkbox"/> Personal perception of the subject</td> </tr> </table> | | | <input type="checkbox"/> Subject notified officer | <input type="checkbox"/> Civilian witness | <input type="checkbox"/> Professional witness | <input type="checkbox"/> Dispatch | <input type="checkbox"/> Personal perception of the subject | | | | | | | | | |
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| <input type="checkbox"/> Professional witness | <input type="checkbox"/> Dispatch | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Personal perception of the subject | | | | | | | | | | | | | | | | |
| 6. To the best of your knowledge, was the person under the influence of alcohol or other drugs at the time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | |
| 7. Were mental health or developmental disabilities professionals contacted for assistance with the subject? <input type="checkbox"/> No (If no, go to Section Three) <input type="checkbox"/> Yes | | | | | | | | | | | | | | | | |