



**SECTION IV - SYNOPSIS**

INCIDENT LOCATION \_\_\_\_\_

INCIDENT DATE/TIME \_\_\_\_\_

INCIDENT SYNOPSIS \_\_\_\_\_

**SECTION V - INTERVIEW** *(Rights advisement in accordance with service policy is required before direct offense questioning)*

Were you operating a vehicle? \_\_\_\_\_ Where were you going? \_\_\_\_\_

What street or highway were you on? \_\_\_\_\_ Direction of travel? \_\_\_\_\_

Where did you start from? \_\_\_\_\_ What time did you start? \_\_\_\_\_ a.m./p.m.

What time is it now? \_\_\_\_\_ What city (county, base, etc.) are you in now? \_\_\_\_\_

What is the date? \_\_\_\_\_ What day of the week is it? \_\_\_\_\_

INTERVIEWER TO FILL IN ACTUAL:	TIME  a.m./p.m.	DAY	DATE	INTERVIEWER'S NAME
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When did you last eat? \_\_\_\_\_ What did you eat? \_\_\_\_\_

What were you doing during the last three hours? \_\_\_\_\_

Have you been drinking? \_\_\_\_\_ What? \_\_\_\_\_ How much? \_\_\_\_\_

Where? \_\_\_\_\_ Started? \_\_\_\_\_ a.m./p.m. Stopped? \_\_\_\_\_

Are you under the influence of an alcoholic beverage now? \_\_\_\_\_

What is your occupation? \_\_\_\_\_ When did you last work? \_\_\_\_\_

Do you have any physical defects? \_\_\_\_\_ If so, what? \_\_\_\_\_

Are you ill? \_\_\_\_\_ If so, what's wrong? \_\_\_\_\_

Do you limp? \_\_\_\_\_ Have you been injured lately? \_\_\_\_\_ If so, what's wrong? \_\_\_\_\_

Were you involved in an accident today? \_\_\_\_\_ Did you get a bump on the head? \_\_\_\_\_

Have you had any alcoholic beverage since the accident? \_\_\_\_\_ If so, what? \_\_\_\_\_

Where? \_\_\_\_\_ How much? \_\_\_\_\_ When? \_\_\_\_\_

Have you seen a doctor or dentist lately? \_\_\_\_\_ If so, who? \_\_\_\_\_ When? \_\_\_\_\_

What for? \_\_\_\_\_ Are you taking tranquilizers, pills or medicines of any kind? \_\_\_\_\_

If so, what kind? (Get sample) \_\_\_\_\_ Last dose? \_\_\_\_\_ a.m./p.m. Do you have epilepsy? \_\_\_\_\_

Diabetes? \_\_\_\_\_ Do you take insulin? \_\_\_\_\_ If so, last dose? \_\_\_\_\_ a.m./p.m.

Have you had any injections of any other drugs recently? \_\_\_\_\_ If so, what for? \_\_\_\_\_

What kind of drug? \_\_\_\_\_ Last dose? \_\_\_\_\_ a.m./p.m. When did you last sleep? \_\_\_\_\_

How much sleep did you have? \_\_\_\_\_ Are you wearing false teeth? \_\_\_\_\_ Do you have a glass eye? \_\_\_\_\_

**HANDWRITING SPECIMEN**

*(Signature and/or anything driver chooses)*