

ALCOHOL INCIDENT REPORT	INSTALLATION	ORI NUMBER	CASE NUMBER <i>(Admin Use only)</i>
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PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 8013; 44 U.S.C. 3103; and E.O. 9397.
PRINCIPAL PURPOSE(S): Used to record information and details of criminal activity which may require investigative action by commanders, supervisor, Military/Security Police, DoD special agents, etc. Used to provide information to the appropriate individuals within DoD organizations who ensure that proper legal action is taken.
ROUTINE USE(S): Information may be disclosed to local, county, state and federal law enforcement or investigatory authorities for investigation and possible criminal prosecution or civil court action. Information extracted from this form may be used in other related criminal and/or civil proceedings.
DISCLOSURE: Voluntary. SSN is used to positively identify the individual making the statement and as a conduit to check past criminal activity records.

SECTION I - SUSPECT DATA

LAST NAME	FIRST NAME	MIDDLE NAME	GRADE	SSN	DATE OF BIRTH <i>(YYYYMMDD)</i>	UNIT/SPONSOR
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SECTION II - INITIAL CONTACT

VEHICLE IN MOTION <input type="checkbox"/> 1. TURNING WITH WIDE RADIUS <input type="checkbox"/> 2. STRADDLING CENTER OR LANE MARKER <input type="checkbox"/> 3. APPEARS TO BE DRUNK <input type="checkbox"/> 4. ALMOST STRIKING OBJECT OR OTHER VEHICLE <input type="checkbox"/> 5. WEAVING (WITHIN OR OUT OF TRAFFIC LANE) <input type="checkbox"/> 6. DRIVING ON OTHER THAN DESIGNATED ROADWAY <input type="checkbox"/> 7. DRIVING INTO OPPOSING OR CROSSING TRAFFIC <input type="checkbox"/> 8. STOPPING INAPPROPRIATELY (OTHER THAN TRAFFIC LANE) <input type="checkbox"/> 9. SLOW RESPONSE TO TRAFFIC SIGNALS <input type="checkbox"/> 10. TURNING ABRUPTLY OR ILLEGALLY <input type="checkbox"/> 11. ACCELERATING OR DECELERATING RAPIDLY <input type="checkbox"/> 12. HEADLIGHTS OFF <input type="checkbox"/> 13. SWERVING <input type="checkbox"/> 14. SPEED SLOWER THAN 10 MPH BELOW LIMIT <input type="checkbox"/> 15. STOPPING WITHOUT CAUSE IN TRAFFIC LANE <input type="checkbox"/> 16. FOLLOWING TOO CLOSELY <input type="checkbox"/> 17. DRIFTING <input type="checkbox"/> 18. TIRES ON CENTER OR LANE MARKER <input type="checkbox"/> 19. BRAKING ERRATICALLY <input type="checkbox"/> 20. SIGNALING INCONSISTENT WITH DRIVING ACTIONS <input type="checkbox"/> 21. OTHER <i>(Specify)</i>	PERSONAL CONTACT <input type="checkbox"/> 1. DRIVER ADMITTED: <input type="checkbox"/> a. OPERATING VEHICLE <input type="checkbox"/> b. CONSUMING ALCOHOL <input type="checkbox"/> c. USING DRUGS <input type="checkbox"/> 2. MOTOR VEHICLE CRASH <input type="checkbox"/> 3. CONTAINER OR ALCOHOL BEVERAGE: <input type="checkbox"/> a. IN VEHICLE <input type="checkbox"/> b. ON PERSON <input type="checkbox"/> 4. ODOR OF ALCOHOLIC BEVERAGE <input type="checkbox"/> 5. BLOOD-SHOT/WATERY EYES <input type="checkbox"/> 6. SLURRED/INCOHERENT SPEECH <input type="checkbox"/> 7. UNSURE BALANCE <input type="checkbox"/> 8. OTHER <i>(Explain)</i>	BEHIND THE WHEEL SCREENING NAME OF TEST SCREENING PERFORMANCE PRE-ARREST SCREENING TIME _____ LOCATION _____ CONDITIONS _____
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SECTION III - STANDARDIZED FIELD SOBRIETY TESTING

HORIZONTAL GAZE NYSTAGMUS (HGN) <input type="checkbox"/> YES <input type="checkbox"/> NO SUSPECT WEARING CONTACTS <table style="width:100%;"> <tr> <td style="width: 50%;">LEFT EYE</td> <td style="width: 50%;">RIGHT EYE</td> </tr> <tr> <td>1. <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>2. <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>3. <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>4. <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>5. <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>6. <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </table> EYE DOES NOT PURSUE SMOOTHLY DISTINCT NYSTAGMUS AT MAX. DEVIATION NYSTAGMUS ONSET PRIOR TO 45 DEGREES OFFICER ADMINISTERING HGN _____	LEFT EYE	RIGHT EYE	1. <input type="checkbox"/> YES <input type="checkbox"/> NO	2. <input type="checkbox"/> YES <input type="checkbox"/> NO	3. <input type="checkbox"/> YES <input type="checkbox"/> NO	4. <input type="checkbox"/> YES <input type="checkbox"/> NO	5. <input type="checkbox"/> YES <input type="checkbox"/> NO	6. <input type="checkbox"/> YES <input type="checkbox"/> NO	TOTAL CLUES _____	WALK AND TURN INSTRUCTION STAGE: <input type="checkbox"/> 1. CANNOT KEEP BALANCE <input type="checkbox"/> 2. STARTS TOO SOON WALKING STAGE: <input type="checkbox"/> 3. STOPS WALKING <input type="checkbox"/> 4. MISSES HEEL TO TOE <input type="checkbox"/> 5. STEPS OFF LINE <input type="checkbox"/> 6. RAISES ARMS <input type="checkbox"/> 7. INCORRECT NUMBER OF STEPS <input type="checkbox"/> 8. INCORRECT TURN <i>(Explain)</i> OTHER <i>(Explain)</i> _____ OFFICER ADMINISTERING TEST _____	TOTAL CLUES _____	ONE LEG STAND <input type="checkbox"/> 1. SWAYS <input type="checkbox"/> 3. HOPS <input type="checkbox"/> 2. HOPS <input type="checkbox"/> 4. FOOT DOWN OTHER <i>(Explain)</i> _____ OFFICER ADMINISTERING TEST _____ NAME OF TEST _____ PERFORMANCE _____
LEFT EYE	RIGHT EYE											
1. <input type="checkbox"/> YES <input type="checkbox"/> NO	2. <input type="checkbox"/> YES <input type="checkbox"/> NO											
3. <input type="checkbox"/> YES <input type="checkbox"/> NO	4. <input type="checkbox"/> YES <input type="checkbox"/> NO											
5. <input type="checkbox"/> YES <input type="checkbox"/> NO	6. <input type="checkbox"/> YES <input type="checkbox"/> NO											

HGN CLUES <table style="width:100%; text-align: center;"> <tr> <td></td> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>6</td> </tr> <tr> <td style="writing-mode: vertical-rl; transform: rotate(180deg);">WALK AND TURN</td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> </tr> </table> <input type="checkbox"/> SHADED <input type="checkbox"/> UNSHADED		0	1	2	3	4	5	6	WALK AND TURN	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	WARNINGS <input type="checkbox"/> A. MIRANDA TIME _____ ID NUMBER _____ <input type="checkbox"/> B. IMPLIED CONSENT TIME _____ ID NUMBER _____ <input type="checkbox"/> C. OBSERVATION TIME STARTED: _____ OBSERVER _____	CHEMICAL TESTING <input type="checkbox"/> A. BLOOD <input type="checkbox"/> B. BREATH <input type="checkbox"/> C. URINE RESULTS: _____ 1. .10 or ABOVE <input type="checkbox"/> 4. .05 OR BELOW <input type="checkbox"/> 2. .08-.09 <input type="checkbox"/> 5. UNKNOWN <input type="checkbox"/> 3. .06-.07 <input type="checkbox"/> 6. REFUSED <input type="checkbox"/> OFFICER _____ TIME _____																																																						
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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

DAY

DATE

INTERVIEWER'S NAME

a.m./p.m.

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)