Tennessee Department of Safety

COMPLAINT AGAINST DEPARTMENT MEMBER

	Driver License #	Date of this Report
Name of Complainant (Please Print)	Date of Birth	Social Security No.
Address		Home Phone
Employer		Business Phone
Date and Time of Incident	Address Where Incident Occurred	

Name of Person(s) You Are Complaining About, If Known.

1. 2.

3. 4.

Have You Reported This To Anyone Previously? ☐ Yes ☐ No	If So, Whom:	Date

PERSONS WHO ACTUALLY SAW EVENT (INCLUDING SELF)

NAME	ADDRESS	PHONE NO.
	Home	
	Business	
	Home	
	Business	
	Home	
	Business	
	Home	
	Business	
	Home	
	Business	

Print Summary of Occurrence of Which You Are Complaining:

(Summary Continued on Other Side)

PLEASE READ BEFORE SIGNING

I understand that it is a violation of T.C.A. 39-16-502 to willfully make a false report. In the event the report is proven false, the information may be provided to the District Attorney for possible prosecution.

Signature of Complainant

Person Receiving Complaint	I.D. No.	Place Taken	Date	Time ☐ A.M. ☐ P.M.

Internal Investigation Use Only: Assigned To:	Date:	Due: