NEW MEXICO CRIME VICTIMS REPARATION COMMISSION
6200 UPTOWN BLVD. NE SUITE 210 • ALBUQUERQUE, NM 87110 Phone (505) 841-9432 Toll-Free (800) 306-6262 Fax (505) 841-9437 Website: www.cvrc.state.nm.us E-mail: cvrc.office@cvrc.nm.gov

LICENSED MEDICAL / MENTAL HEALTH / TRIBAL PROVIDER VERIFICATION OF INCIDENT
(INFORMATION REQUESTED WILL BE USED FOR OFFICIAL USE ONLY)

Victim name and date of birth:

PART I: LICENSED PROVIDER IDENTIFICATION INFORMATION

A. Provider name:

B. License Number:

C. Date the crime was reported:

PART II: CRIME VERIFICATION INFORMATION

A. Reported crime (e.g. domestic violence, sexual assault, etc.):

B. Date and location of crime (on or about):

C. What injuries (physical and/or emotional) were sustained by the victim:

D. Please provide a brief, but detailed, summary of the incident as reported to you from the victim/claimant:

E. To the best of your knowledge, did the victim's actions cause, in a substantial way what happened?

☐ No ☐ Yes, *If yes, please explain (e.g. acting in commission of a crime, gang related, etc.)

F. Was the incident reported to law enforcement? ☐ No ☐ Yes

If yes, please list the law enforcement agency:

PART III: AUTHORIZATION INFORMATION

Signature of the person who completed this form:

Print name:

Provider Phone Number or Email Address:

Date: