Please Note: This form must be submitted with an invoice to NCC.SAPP@nebraska.gov

| | DEMOGRAPHICAL DATA REPORTING FORM |
|---|---|
| 1. | Patient Name: |
| 2. | Date of Service: |
| 3. | Date of Assault if known: |
| 4. | Sexual Assault Kit completed: ☐ Yes ☐ No |
| 5. | If Yes to 4, identifier # (located on top of Kit box): |
| 6. | Reported to law enforcement: ☐ Yes ☐ No |
| 7. | If Yes to 6, name of law enforcement agency: |
| 8. | DOB: |
| 9. | Race: |
| 10. | Gender: ☐ M ☐ F |
| 11. | County in which assault occurred: |