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 (if known):