






Reporting Form Hate Crime





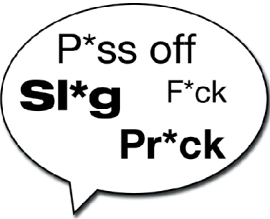


	Date of Incident:
	Date of Report:
	Please tell us your name if you have been bullied or hurt: My Name is:
	Please tell us your address:
	My Telephone Number is: Daytime: Evening Time: Mobile:



Part 1 - What Happened To You?

To tell us about what happened, answer the question by ticking the right boxes.



	I was called names	<input type="checkbox"/>
	I had people laugh at me	<input type="checkbox"/>
	I was sworn at	<input type="checkbox"/>
	I had something stolen	<input type="checkbox"/>
	I was hit, kicked or touched in a way I didn't like	<input type="checkbox"/>



I had something thrown at me

I had something thrown at my house



When this happened did you do anything at the time?

Yes

No








What did you do?

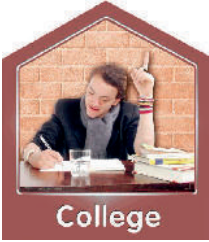



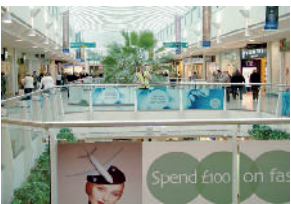

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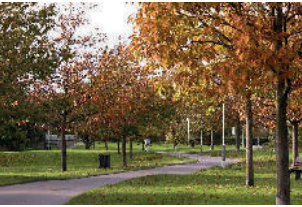
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Part 2: Where Did It Happen?






	<p>At the bus stop?</p> <p>Which bus stop?.....</p>	<input type="checkbox"/>
	<p>On the bus?</p> <p>Which bus?.....</p>	<input type="checkbox"/>
	<p>On the train or at the station?</p> <p>Which train or at which station?.....</p>	<input type="checkbox"/>
	<p>On the street?</p> <p>Which street?.....</p>	<input type="checkbox"/>
	<p>At a day centre?</p> <p>Which day centre?.....</p>	<input type="checkbox"/>


 <p>College</p>	<p>At college?</p> <p>Which college?.....</p>	<input type="checkbox"/>
	<p>At work?</p>	<input type="checkbox"/>
	<p>At home?</p>	<input type="checkbox"/>
	<p>At the pub?</p> <p>Which pub?.....</p>	<input type="checkbox"/>
	<p>At the shops?</p> <p>Which shops?.....</p>	<input type="checkbox"/>
	<p>At the cinema / theatre?</p> <p>Which cinema or theatre?</p>	<input type="checkbox"/>


	<p>At the sports centre?</p>	<input type="checkbox"/>
	<p>In the park?</p>	<input type="checkbox"/>
<p>?</p>	<p>Any other place?</p>	<input type="checkbox"/>
	<p>Which sports centre?</p> <p>Which park?.....</p> <p>Where?.....</p>	





Part 3: Who Did This To You?

	One person?	<input type="checkbox"/>
	Two people?	<input type="checkbox"/>
	A group of people?	<input type="checkbox"/>
	Was it a man?	<input type="checkbox"/>
	Was it a woman?	<input type="checkbox"/>

	<p>Were there both men and women?</p>	<input type="checkbox"/>
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	<p>Were they adults?</p>	<input type="checkbox"/>
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	<p>Were they teenagers?</p>	<input type="checkbox"/>
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	<p>Were they children?</p>	<input type="checkbox"/>
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Do you know their names?

Yes No

If you do, what are their names?

.....
.....



Do you know where they live?

Yes No

Have they done this before?

Yes No

Can you give a description of the person or people that did this?

Yes No



What was their hair colour?

.....

?



What was their skin colour?

.....



Did they wear glasses?

Yes No

Is there anything else you can tell us?

.....
.....





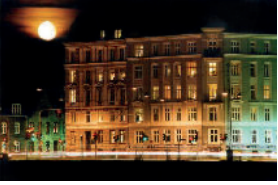

Did anyone else see this happen?

Yes No

Who saw it?



Part 4: When Did It Happen?

	What was the date?.....
	Did it happen in the day time? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Did it happen in the evening / night time? <input type="checkbox"/> Yes <input type="checkbox"/> No
	What was the time?.....



Further Information



Has anyone helped you to fill in this form?

Yes

No

If yes, can you ask them to fill in the rest of this form?

Name:

Occupation:

Address:

.....

.....

Telephone number:

Fax number:

Email:

What action have you taken so far?

.....

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