

**Supplemental Victim Statement
Report of Stolen or Counterfeit Checks**

Name of Police Agency: _____ Case #: _____
Date of Police Report: ____/____/____ Police Contact(Phone/Person): _____

REPORTING VICTIM INFORMATION

Name: _____ Date of Birth: ____/____/____
Address: _____ City/State/Zip: _____
Daytime Phone: _____ Evening Phone: _____
Exact names on reported checks: _____

Exact address on reported checks: _____
Exact city, state, zip on reported checks: _____

Was your driver license or state issue identification stolen? Yes No

If YES what was the state of issue and the number? _____
State ID numbers, such as M230-230-330-330

FINANCIAL INSTITUTION (BANK OR CREDIT UNION) INFORMATION FROM REPORTED CHECKS

Bank Name: _____ Bank Routing #: _____
Bank Address: _____ (*) Bank Account #: _____
Bank Phone #: _____

(* Use FULL number from the bottom of reported checks - please print with spacing exactly as it appears on check.

VICTIM'S ACKNOWLEDGEMENT AND AGREEMENT WITH FINANCIAL & RETAILERS PROTECTION ASSOCIATION:

I understand that making a false statement is subject to federal and/or state statutes and may be punishable by fines and/or imprisonment.
I understand that making a false report to a police officer is a criminal misdemeanor offense.

As an owner of the account, I agree to hold law enforcement agencies, retailers, banks, credit unions, check authorization services or any reporting association harmless from any personal injury, loss, or general liability, for refusing to accept the reported stolen checks. I understand that am responsible for immediately closing this checking account by contacting my financial institution and that checks that have been written on the account may not be accepted by anyone for goods or services. I understand that I must cooperate with merchants and businesses that may have accepted checks in good faith. I agree to complete the required affidavits of forgery and may be asked to file additional police reports.

Please acknowledge by checking the box to indicate you understand and will comply with each of the following statements (must affirm by indicating yes to each):

Yes No

- I am an authorized owner / signer on the described account according to the records of my financial institution.
- I agree to immediately contact my financial institution and ask them to close the affected checking account.
- I will notify all authorized signers of the closing of this checking account to avoid any embarrassment to them.
- I understand that completing this form does not protect me from any check loss.
- I understand that the information on this form will be used as a public service to victims.
- I understand this document is a public record available to law enforcement agencies, financial institutions, merchants and all businesses including hotels, restaurants, and casinos etc.
- I agree to hold harmless the companies listed on the reverse of this form if they refuse to accept checks drawn on this account.
- I voluntarily authorized the release of this information and understand I will need to contact my bank or credit union with in the next business day to insure that any and all valid checks outstanding are properly paid.

Signature of account owner (required)

Date

Signature of account co-owner (if available, optional signature)

Date

Police Department or Victim can fax to 651-304-1489 for distribution of this public record to retailers and financial institutions. If mailing please send to: Financial & Retailers Protection Association, PO Box 251037, Woodbury MN 55125

RETAIN A COPY OF THIS FORM. INFORMATION CANNOT BE CANCELLED AFTER BEING COMMUNICATED!!

FAX ONLY THIS PAGE