DEPARTMENT OF PUBLIC WELFARE – OFFICE OF MENTAL HEALTH VICTIM NOTIFICATION PROGRAM ENROLLMENT FORM

VICTIM INFORMATION: TO BE COMPLETED BY THE VICTIM

Your Name: _____

Street/Rt/P.O. Box #: _____

City: _____ State: _____ Zip: _____

Mother's Maiden Name: _____

Daytime Phone #: _____

Check all that apply: _____ Crime Victim _____ Parent/Legal Guardian or Victim

_____ Family Member of Victim _____ Family Member of Offender

Special instructions for contacting you: _____

****

OFFENDER INFORMATION: TO BE PROVIDED BY THE DISTRICT ATTORNEY, JAIL WARDEN, COUNTY VICTIM/WITNESS COORDINATOR OR DEPARTMENT OF CORRECTIONS OFFICE OF VICTIM SERVICES

Offender's Name: _____

Convicting County: _____ Date of Birth: _____

Criminal Charges: _____ Sentence: _____

Date of Sentence: _____ PSP # / SID #: _____

DOC inmate # / if applicable _____ Social Security #: _____

Check One: Sentenced to DOC Sentenced to County Jail