



**LOST / STOLEN CONTROLLED SUBSTANCE**

**WITNESS / VICTIM STATEMENT**



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DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ TYPE OF INCIDENT: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SOC: \_\_\_\_\_

ADDRESS (PHYSICAL): \_\_\_\_\_

PHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ OTHER: \_\_\_\_\_

LOCATION OF INCIDENT: \_\_\_\_\_

**HAVE YOU EVER BEEN CONVICTED OF A CHARGE OF POSSESSION OF A CONTROLLED SUBSTANCE? IF YES, WHEN AND WHERE?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU EVER MADE A REPORT OF HAVING A LOST OF STOLEN PRESCRIPTION? IF YES, WHEN, WHERE AND WHAT TYPE OF MEDICATION?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DESCRIBE IN DETAIL HOW YOUR MEDICATION WAS LOST OR STOLEN:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_