

# FORENSIC MEDICAL EXAMINATION PROGRAM

Victim: \_\_\_\_\_

Victim DOB: \_\_\_\_\_

LE Case Number: \_\_\_\_\_

Date of crime or Last Date of Occurrence: \_\_\_\_\_

Forensic Medical Examinations (FME's) address the immediate needs of victims of sexual assault to ensure they get the help they need. The Georgia Crime Victims Compensation Program will pay for the cost of a forensic medical exam up to \$1,000 for a sexual assault that occurred in Georgia.

**Service Provider Instructions:** When applying for an FME payment for a sexual abuse allegation for a minor or developmentally disabled adult, please submit this form with the Application for Payment.

The medical provider and an investigative agency representative [e.g. law enforcement, Department of Family and Children Services (DFCS), or Adult Protective Services (APS)] must complete the respective sections below:

## SECTION 1 - To be completed by Medical Provider

1. The FME was conducted in order to gather evidence related to an alleged sexual offense? \_\_\_ Yes \_\_\_ No
2. Was a sexual assault kit collected during the examination?  Yes  No
  - a. If yes, list the sexual assault kit tracking #: \_\_\_\_\_
  - b. If no, why was a kit not collected? \_\_\_\_\_
3. Please list all other evidence that was collected: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Was the FME conducted at the request of law enforcement, DFCS or APS?  Yes \_\_\_ No  
 If no, list the date law enforcement, DFCS or APS was notified of the alleged sexual offense: \_\_\_\_\_

By signing this form, I attest that, to the best of my knowledge and belief, the information provided in SECTION 1 of this form is true and correct.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Medical Facility/Medical Provider: \_\_\_\_\_

Phone: \_\_\_\_\_

## SECTION 2 - To be completed by Law Enforcement, DFCS or APS

By signing this form, I attest that I have reviewed SECTION 1 of this form and that our agency either requested that an FME be conducted or that I was notified of the alleged sexual offense for the victim named above.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Investigative Agency: \_\_\_\_\_

Phone: \_\_\_\_\_

**Note:** Unless authorized or required by law, the information provided in this form shall remain **CONFIDENTIAL**, and shall not be shared with any individual or agency other than the agency(ies) investigating the alleged sexual abuse, the medical provider that performed the FME, and the Georgia Crime Victims Compensation Program.