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SUSPECT <input style="width: 40px; height: 20px;" type="checkbox"/>	VICTIM <input style="width: 40px; height: 20px;" type="checkbox"/>	RPT. PERSON <input style="width: 40px; height: 20px;" type="checkbox"/>	WITNESS <input style="width: 40px; height: 20px;" type="checkbox"/>	OTHER <input style="width: 40px; height: 20px;" type="checkbox"/>
TYPE OF INCIDENT/OFFENSE:			LOCATION/ADDRESS:	

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