

## ARREST / NOTICE TO APPEAR

1. Arrest (No Warrant) 3. Request for Warrant  
2. N.T.A. 4. Request for Capias  
5. Juvenile Referral

3

JUVENILE

|                                                                |                                                                                                                                                                                                                                                                                                                 |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|------------------------------------------------|-------------------------------------------------------|
| AD<br>M<br>I<br>N<br>I<br>S<br>T<br>R<br>A<br>T<br>I<br>O<br>N | OBTS Number                                                                                                                                                                                                                                                                                                     | Agency ORI Number<br><b>0500200</b>                                              |                                                                                            | Agency Name<br><b>Boca Raton Police Department</b>                         |                                                                                | Agency Report Number (N.T.A.'s only)<br><b>3   2   2022-012585</b>                                                                                                                                                          |                                                                                                                                                                                              | If Weapon Seized<br>Enter Type <b>UNARMED</b>                                                                                                                                                                                                             |       | Multiple<br>Clearance<br>Indicator<br><b>0</b> |                                                       |
|                                                                | Charge Type:<br>Check as many<br>as apply                                                                                                                                                                                                                                                                       | <input type="checkbox"/> 1. Felony<br><input type="checkbox"/> 2. Traffic Felony | <input type="checkbox"/> 3. Misdemeanor<br><input type="checkbox"/> 4. Traffic Misdemeanor | <input type="checkbox"/> 5. Ordinance<br><input type="checkbox"/> 6. Other |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Location of Arrest (Including Name of Business)<br><b>N/A</b>                                                                                                                                                                                                                                                   |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Date of Arrest                                                                                                                                                                                                                                                                                                  | Time of Arrest                                                                   | Booking Date<br><b>09/30/2022</b>                                                          | Booking Time<br><b>13:15</b>                                               | Jail Date                                                                      | Jail Time                                                                                                                                                                                                                   | Location of Vehicle<br><b>N/A</b>                                                                                                                                                            |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Name (Last, First, Middle)<br><b>COSTANZA, GABRIELLE ELEESE</b>                                                                                                                                                                                                                                                 |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                | Alias (Name, DOB, Soc. Sec. #, Etc.)<br><b>Alias:</b> |
|                                                                | Race<br>W - White<br>B - Black<br><b>W</b>                                                                                                                                                                                                                                                                      | Sex<br>M - Male<br>F - Female<br><b>F</b>                                        | Date of Birth<br><b>04/26/1982</b>                                                         | Height<br><b>5'02</b>                                                      | Weight<br><b>120</b>                                                           | Eye Color                                                                                                                                                                                                                   | Hair Color<br><b>BLACK</b>                                                                                                                                                                   | Complexion                                                                                                                                                                                                                                                | Build |                                                |                                                       |
|                                                                | Scars, Marks, Tattoos, Unique Physical Features (Location, Type, Description)                                                                                                                                                                                                                                   |                                                                                  |                                                                                            |                                                                            |                                                                                | Marital Status<br><b>M</b>                                                                                                                                                                                                  | Religion                                                                                                                                                                                     | Indication of:<br>Alcohol Influence Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk. <input type="checkbox"/><br>Drug Influence Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unk. <input type="checkbox"/> |       |                                                |                                                       |
|                                                                | Local Address (Street, Apt. Number) (City) (State) (Zip)<br><b>1133 SW 12TH RD, BOCA RATON, FL 33486</b>                                                                                                                                                                                                        |                                                                                  |                                                                                            |                                                                            |                                                                                | Phone<br><b>(954) 806-4550</b>                                                                                                                                                                                              |                                                                                                                                                                                              | Residence Type:<br>1. City 3. Florida<br>2. County 4. Out of State                                                                                                                                                                                        |       |                                                |                                                       |
|                                                                | Permanent Address (Street, Apt. Number) (City) (State) (Zip)<br><b>1133 SW 12TH RD, BOCA RATON, FL 33486</b>                                                                                                                                                                                                    |                                                                                  |                                                                                            |                                                                            |                                                                                | Phone<br><b>(954) 806-4550</b>                                                                                                                                                                                              |                                                                                                                                                                                              | Address Source                                                                                                                                                                                                                                            |       |                                                |                                                       |
|                                                                | Business Address (Name, Street) (City) (State) (Zip)                                                                                                                                                                                                                                                            |                                                                                  |                                                                                            |                                                                            |                                                                                | Phone                                                                                                                                                                                                                       |                                                                                                                                                                                              | Occupation<br><b>Piano Teacher</b>                                                                                                                                                                                                                        |       |                                                |                                                       |
|                                                                | D/L Number, State<br><b>C235285826460 / FL</b>                                                                                                                                                                                                                                                                  |                                                                                  | INS Number                                                                                 |                                                                            | Place of Birth (City, State)                                                   |                                                                                                                                                                                                                             | Citizenship                                                                                                                                                                                  |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Co-Defendant Name (Last, First, Middle)                                                                                                                                                                                                                                                                         |                                                                                  | Race                                                                                       | Sex                                                                        | Date of Birth                                                                  |                                                                                                                                                                                                                             | <input type="checkbox"/> 1. Arrested <input type="checkbox"/> 3. Felony <input type="checkbox"/> 5. Juvenile<br><input type="checkbox"/> 2. At Large <input type="checkbox"/> 4. Misdemeanor |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Co-Defendant Name (Last, First, Middle)                                                                                                                                                                                                                                                                         |                                                                                  | Race                                                                                       | Sex                                                                        | Date of Birth                                                                  |                                                                                                                                                                                                                             | <input type="checkbox"/> 1. Arrested <input type="checkbox"/> 3. Felony <input type="checkbox"/> 5. Juvenile<br><input type="checkbox"/> 2. At Large <input type="checkbox"/> 4. Misdemeanor |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Parent <input type="checkbox"/> Other: _____ Name (Last, First, Middle)                                                                                                                                                                                                                                         |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Legal Custodian <input type="checkbox"/> _____                                                                                                                                                                                                                                                                  |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Address (Street, Apt. Number) (City) (State) (Zip)                                                                                                                                                                                                                                                              |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Business Phone                                                                                                                                                                                                                                                                                                  |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Notified by: (Name)                                                                                                                                                                                                                                                                                             |                                                                                  | Date                                                                                       | Time                                                                       | JUVENILE DISPOSITION<br>1. Handled/Processed within<br>Department and Released |                                                                                                                                                                                                                             | 2. TOT JAC<br>3. Incarcerated                                                                                                                                                                |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Released To: (Name)                                                                                                                                                                                                                                                                                             |                                                                                  | Relationship                                                                               | Date                                                                       | Time                                                                           |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | The above address was provided by <input type="checkbox"/> defendant and/or <input type="checkbox"/> defendant's parents.<br>The child and/or parent was told to keep the Juvenile Court Clerk's Office<br>(Phone 355-2526) informed of any change of address.                                                  |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Property Crime? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                             |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Description of Property                                                                                                                                                                                                                                                                                         |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Value of Property                                                                                                                                                                                                                                                                                               |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Drug Activity S. Sell R. Smuggle K. Disperse/ M. Manufacture/ Z. Other<br>N. N/A B. Buy D. Deliver E. Use Produce/ Cultivate<br>P. Possess T. Traffic                                                                                                                                                           |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Drug Type N. N.A. B. Barbiturate H. Hallucinogen P. Paraphernalia/ U. Unknown<br>A. Amphetamine C. Cocaine M. Marijuana Equipment Z. Other<br>E. Heroin O. Opium/Deriv. S. Synthetic                                                                                                                            |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Charge Description<br><b>BATTERY / DOMESTIC BATTERY</b>                                                                                                                                                                                                                                                         |                                                                                  |                                                                                            |                                                                            |                                                                                | Statute Violation Number<br><b>784.03(1)</b>                                                                                                                                                                                |                                                                                                                                                                                              | Violation of ORD #                                                                                                                                                                                                                                        |       |                                                |                                                       |
|                                                                | Drug Activity                                                                                                                                                                                                                                                                                                   | Drug Type<br><b>N</b>                                                            | Amount Unit                                                                                | Offense #                                                                  | Counts<br><b>1</b>                                                             | Domestic Violence<br><input type="checkbox"/> Y <input checked="" type="checkbox"/> N                                                                                                                                       | Warrant Capias Number                                                                                                                                                                        | Bond                                                                                                                                                                                                                                                      |       |                                                |                                                       |
|                                                                | Charge Description                                                                                                                                                                                                                                                                                              |                                                                                  |                                                                                            |                                                                            |                                                                                | Statute Violation Number                                                                                                                                                                                                    |                                                                                                                                                                                              | Violation of ORD #                                                                                                                                                                                                                                        |       |                                                |                                                       |
|                                                                | Drug Activity                                                                                                                                                                                                                                                                                                   | Drug Type                                                                        | Amount Unit                                                                                | Offense #                                                                  | Counts                                                                         | Domestic Violence<br><input type="checkbox"/> Y <input type="checkbox"/> N                                                                                                                                                  | Warrant Capias Number                                                                                                                                                                        | Bond                                                                                                                                                                                                                                                      |       |                                                |                                                       |
|                                                                | Charge Description                                                                                                                                                                                                                                                                                              |                                                                                  |                                                                                            |                                                                            |                                                                                | Statute Violation Number                                                                                                                                                                                                    |                                                                                                                                                                                              | Violation of ORD #                                                                                                                                                                                                                                        |       |                                                |                                                       |
|                                                                | Drug Activity                                                                                                                                                                                                                                                                                                   | Drug Type                                                                        | Amount Unit                                                                                | Offense #                                                                  | Counts                                                                         | Domestic Violence<br><input type="checkbox"/> Y <input type="checkbox"/> N                                                                                                                                                  | Warrant Capias Number                                                                                                                                                                        | Bond                                                                                                                                                                                                                                                      |       |                                                |                                                       |
|                                                                | Health / Apparent Physical Condition of Defendant<br><b>N/A</b>                                                                                                                                                                                                                                                 |                                                                                  |                                                                                            |                                                                            |                                                                                | Any knowledge of the following: <input type="checkbox"/> Mental <input type="checkbox"/> Escape Risk <input type="checkbox"/> Medication <input type="checkbox"/> Deformities <input type="checkbox"/> Injuries<br>Explain: |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Check which applies: <input type="checkbox"/> Released O.R. <input type="checkbox"/> Released to Parent/Guardian <input type="checkbox"/> T.O.T. County Jail                                                                                                                                                    |                                                                                  |                                                                                            |                                                                            |                                                                                | PROPERTY - Received By                                                                                                                                                                                                      |                                                                                                                                                                                              | Released By                                                                                                                                                                                                                                               |       | Released To                                    |                                                       |
|                                                                | <input type="checkbox"/> Posted Bond <input type="checkbox"/> South County Mental Health                                                                                                                                                                                                                        |                                                                                  |                                                                                            |                                                                            |                                                                                |                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Transported By                                                                                                                                                                                                                                                                                                  |                                                                                  |                                                                                            |                                                                            |                                                                                | Date Transported<br>/ /                                                                                                                                                                                                     | Time Transported                                                                                                                                                                             | Other                                                                                                                                                                                                                                                     |       |                                                |                                                       |
|                                                                | <input type="checkbox"/> INSTRUCTION NO. 1 - Mandatory appearance in court<br><input checked="" type="checkbox"/> INSTRUCTION NO. 2 - You need not appear in Court<br>but must comply with instructions on Page 2.                                                                                              |                                                                                  |                                                                                            |                                                                            |                                                                                | Location (Court, Room)<br><b>South County 200 W Atlantic Ave Delray Beach, FL 33444</b>                                                                                                                                     |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                |                                                                                                                                                                                                                                                                                                                 |                                                                                  |                                                                                            |                                                                            |                                                                                | Court Date and Time                                                                                                                                                                                                         |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | I AGREE TO APPEAR AT THE TIME AND PLACE DESIGNATED TO ANSWER THE OFFENSE CHARGED OR TO PAY THE FINE SUBSCRIBED. I UNDERSTAND THAT SHOULD I WILLFULLY FAIL TO APPEAR BEFORE THE COURT AS REQUIRED BY THIS NOTICE TO APPEAR, THAT I MAY BE HELD IN CONTEMPT OF COURT AND A WARRANT FOR MY ARREST SHALL BE ISSUED. |                                                                                  |                                                                                            |                                                                            |                                                                                | No<br>Photo<br>Available                                                                                                                                                                                                    |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Signature of Defendant (or Juvenile and Parent/Custodian)                                                                                                                                                                                                                                                       |                                                                                  |                                                                                            |                                                                            |                                                                                | Date Signed                                                                                                                                                                                                                 |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | HOLD for Other Agency                                                                                                                                                                                                                                                                                           |                                                                                  |                                                                                            |                                                                            |                                                                                | Signature of Arresting Officer<br><b>MCERLAIN, S.</b>                                                                                                                                                                       |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | <input type="checkbox"/> Dangerous <input type="checkbox"/> Resisted Arrest<br><input type="checkbox"/> Suicidal <input type="checkbox"/> Other                                                                                                                                                                 |                                                                                  |                                                                                            |                                                                            |                                                                                | Name of Arresting Officer (Print)<br><b>MCERLAIN, S.</b>                                                                                                                                                                    |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Intake Deputy I.D. #                                                                                                                                                                                                                                                                                            |                                                                                  |                                                                                            |                                                                            |                                                                                | Transferring Officer I.D. #<br><b>665</b>                                                                                                                                                                                   |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                | Pouch #                                                                                                                                                                                                                                                                                                         |                                                                                  |                                                                                            |                                                                            |                                                                                | Agency<br><b>BOCA</b>                                                                                                                                                                                                       |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                |                                                                                                                                                                                                                                                                                                                 |                                                                                  |                                                                                            |                                                                            |                                                                                | Witness here if subject signed with an "X".                                                                                                                                                                                 |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |
|                                                                |                                                                                                                                                                                                                                                                                                                 |                                                                                  |                                                                                            |                                                                            |                                                                                | PAGE<br><b>1 OF 1</b>                                                                                                                                                                                                       |                                                                                                                                                                                              |                                                                                                                                                                                                                                                           |       |                                                |                                                       |

## DOMESTIC VIOLENCE PROBABLE CAUSE

## AFFIDAVIT

Palm Beach County

|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          |     |                                                    |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
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| A<br>D<br>M<br>I<br>N                                                                                                                                                                                                                                                                                                                                                                                                                           | Date / Time<br><b>09/30/2022 13:10</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Agency ORI Number<br><b>FL FL0500200</b> |     | Agency Name<br><b>BOCA RATON POLICE DEPARTMENT</b> | Agency Report Number<br><b>3 2 2022-012585</b> |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Name (Last, First, Middle)<br><b>COSTANZA, GABRIELLE ELEESE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          |     |                                                    | Alias                                          | Race<br><b>W</b>              | Sex<br><b>F</b> | Date of Birth<br><b>04/26/1982</b> |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
| CHRG                                                                                                                                                                                                                                                                                                                                                                                                                                            | Charge Description<br><b>784.03(1) BATTERY / DOMESTIC BATTERY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                          |     |                                                    |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
| V<br>I<br>C<br>T<br>I<br>M                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          |     |                                                    |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
| D<br>E<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                     | DEFENDANT'S STATEMENTS: Written <input type="checkbox"/> Taped <input type="checkbox"/> Oral <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |     | OBSERVATIONS OF VICTIM (PHYSICAL & EMOTIONAL):     |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | VICTIM'S STATEMENTS: Written <input type="checkbox"/> Taped <input checked="" type="checkbox"/> Oral <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                          |     |                                                    |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
| A<br>D<br>D<br>I<br>T<br>I<br>O<br>N<br>A<br>L<br><br>I<br>N<br>F<br>O<br>R<br>M<br>A<br>T<br>I<br>O<br>N                                                                                                                                                                                                                                                                                                                                       | RELATIONSHIP BETWEEN VICTIM & SUSPECT<br>[REDACTED]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                          |     |                                                    |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <table border="0"><tr><td>PHOTOGRAPHS:</td><td>Scene:</td><td><input type="checkbox"/></td><td>YES</td><td><input checked="" type="checkbox"/></td><td>NO</td><td></td><td></td></tr><tr><td></td><td>Victim:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td></td><td></td></tr><tr><td></td><td>911 CALL:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td>CALLER:</td><td></td></tr><tr><td></td><td>WEAPON USED:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td>TYPE:</td><td></td></tr><tr><td></td><td>WITNESSES:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td>(If YES, attach witness list)</td><td></td></tr><tr><td></td><td>INJURIES:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td></td><td></td></tr><tr><td></td><td>MEDICAL TREATMENT:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td></td><td></td></tr><tr><td></td><td>AT: Scene:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td>PARAMEDICS:</td><td></td></tr><tr><td></td><td>Hospital:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td>PHYSICIAN(S) / HOSPITAL:</td><td></td></tr><tr><td></td><td>ACT COMMITTED IN PRESENCE OF MINOR(S):</td><td><input checked="" type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td></td><td>NAMES/AGES:</td><td></td></tr><tr><td></td><td>H. R. S. NOTIFIED:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td></td><td></td></tr><tr><td></td><td>VICTIM PREGNANT:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td></td><td></td></tr><tr><td></td><td>VIOLATION OF RESTRAINING ORDER:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td>CASE #:</td><td></td></tr><tr><td></td><td>PRIOR HISTORY OF DOMESTIC VIOLENCE:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td></td><td></td></tr><tr><td></td><td>ALCOHOL OR DRUGS INVOLVED:</td><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td></td><td></td></tr></table> |                                          |     |                                                    |                                                |                               |                 |                                    | PHOTOGRAPHS: | Scene: | <input type="checkbox"/> | YES | <input checked="" type="checkbox"/> | NO |  |  |  | Victim: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  |  |  |  | 911 CALL: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  | CALLER: |  |  | WEAPON USED: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  | TYPE: |  |  | WITNESSES: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  | (If YES, attach witness list) |  |  | INJURIES: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  |  |  |  | MEDICAL TREATMENT: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  |  |  |  | AT: Scene: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  | PARAMEDICS: |  |  | Hospital: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  | PHYSICIAN(S) / HOSPITAL: |  |  | ACT COMMITTED IN PRESENCE OF MINOR(S): | <input checked="" type="checkbox"/> |  | <input type="checkbox"/> |  | NAMES/AGES: |  |  | H. R. S. NOTIFIED: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  |  |  |  | VICTIM PREGNANT: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  |  |  |  | VIOLATION OF RESTRAINING ORDER: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  | CASE #: |  |  | PRIOR HISTORY OF DOMESTIC VIOLENCE: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  |  |  |  | ALCOHOL OR DRUGS INVOLVED: | <input type="checkbox"/> |  | <input checked="" type="checkbox"/> |  |  |
| PHOTOGRAPHS:                                                                                                                                                                                                                                                                                                                                                                                                                                    | Scene:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/>                 | YES | <input checked="" type="checkbox"/>                | NO                                             |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Victim:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 911 CALL:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                | CALLER:                       |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | WEAPON USED:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                | TYPE:                         |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | WITNESSES:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                | (If YES, attach witness list) |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | INJURIES:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | MEDICAL TREATMENT:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | AT: Scene:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                | PARAMEDICS:                   |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Hospital:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                | PHYSICIAN(S) / HOSPITAL:      |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ACT COMMITTED IN PRESENCE OF MINOR(S):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input checked="" type="checkbox"/>      |     | <input type="checkbox"/>                           |                                                | NAMES/AGES:                   |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | H. R. S. NOTIFIED:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | VICTIM PREGNANT:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | VIOLATION OF RESTRAINING ORDER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                | CASE #:                       |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | PRIOR HISTORY OF DOMESTIC VIOLENCE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ALCOHOL OR DRUGS INVOLVED:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/>                 |     | <input checked="" type="checkbox"/>                |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
| N<br>A<br>R<br>R                                                                                                                                                                                                                                                                                                                                                                                                                                | MVR activated<br>On 09/30/22 at 1045hrs, I responded to 100 NW 2nd Ave (BRPD), in reference to a delayed domestic disturbance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                          |     |                                                    |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |
| STATE OF FLORIDA<br>COUNTY OF PALM BEACH<br>Appeared before me, <u>C</u> personally known to me, who, being first duly sworn, says that the facts above, based upon my investigation, are true.<br><br><u>[Signature]</u><br>SIGNATURE OF ARRESTING OFFICER<br><br>Sworn to and subscribed to before me this <u>2</u> day of <u>October</u> , <u>2022</u><br><br><u>[Signature]</u><br>NOTARY PUBLIC / CLERK OF COURT / OFFICER (F.S.S. 117.10) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          |     |                                                    |                                                |                               |                 |                                    |              |        |                          |     |                                     |    |  |  |  |         |                          |  |                                     |  |  |  |  |           |                          |  |                                     |  |         |  |  |              |                          |  |                                     |  |       |  |  |            |                          |  |                                     |  |                               |  |  |           |                          |  |                                     |  |  |  |  |                    |                          |  |                                     |  |  |  |  |            |                          |  |                                     |  |             |  |  |           |                          |  |                                     |  |                          |  |  |                                        |                                     |  |                          |  |             |  |  |                    |                          |  |                                     |  |  |  |  |                  |                          |  |                                     |  |  |  |  |                                 |                          |  |                                     |  |         |  |  |                                     |                          |  |                                     |  |  |  |  |                            |                          |  |                                     |  |  |

COURT

STATE ATTORNEY

CENTRAL RECORDS

JAIL

CRIME ANALYSIS

P. I. O.

## DOMESTIC VIOLENCE PROBABLE CAUSE

## AFFIDAVIT

Palm Beach County  
Narrative Continuation

|                       |                                          |                                                    |  |                                                    |
|-----------------------|------------------------------------------|----------------------------------------------------|--|----------------------------------------------------|
| A<br>D<br>M<br>I<br>N | Date / Time<br><b>09/30/2022 13:10</b>   | Agency Name<br><b>BOCA RATON POLICE DEPARTMENT</b> |  | Agency Report Number<br><b>3   2   2022-012585</b> |
|                       | Agency ORI Number<br><b>FL FLO500200</b> |                                                    |  |                                                    |

Upon arrival I met with Victim [REDACTED]. [REDACTED] stated he resides at 1133 SW 12th Rd, Boca Raton. [REDACTED] advised he resides at this address with [REDACTED] later identified as Defendant Gabrielle Costanza, his [REDACTED] and his [REDACTED]. Subject #3 [REDACTED].

[REDACTED] stated on 09/24/22 at 1200hrs, he was at his residence. [REDACTED] advised he was with Gabrielle in the laundry room. [REDACTED] explained they were having an argument over Gabrielle not maintaining the kids laundry. [REDACTED] stated he was using his cell phone to record Gabrielle. [REDACTED] explained he was holding his cell phone near his chest. [REDACTED] advised during the argument, Gabrielle came toward him and tried to grab his cell phone. [REDACTED] explained he uses his cell phone to record his dealings with Gabrielle, due to past allegations from Gabrielle against him. I viewed [REDACTED] cell phone recording. I observed [REDACTED] and Gabrielle having an argument in the laundry room, when Gabrielle moves toward [REDACTED] uses her hands and makes contact with [REDACTED] where [REDACTED] is holding his cell phone. [REDACTED] then moves away and the recording stops. [REDACTED] advised he was not injured. [REDACTED] explained both [REDACTED] were present. A copy of this footage was placed into evidence at the BRPD. [REDACTED] stated Gabrielle was currently in West Palm Beach. I attempted to contact Gabrielle via her cell phone with negative results. [REDACTED] recorded statement was also placed into evidence at the BRPD.

I spoke with the Department of Children & Families Employee [REDACTED] advised DCF would only document this incident.

On 09/30/22 at 1525hrs, I responded to [REDACTED]. I spoke with Gabrielle outside in her driveway. I explained to Gabrielle I was conducting a criminal investigation regarding a matter between [REDACTED] and herself. Gabrielle requested to contact her attorney. After speaking with her attorney, Gabrielle invoked her right to remain silent and not speak with me. I ended this conversation.

Based on the above statements and physical evidence present, I will file a warrant against Gabrielle with the State Attorney's Office for (1) Count of Domestic Battery F.S.S. 784.03(1).

STATE OF FLORIDA  
COUNTY OF PALM BEACH

Appeared before me, ✓ personally known to me, who, being first duly sworn, says that the facts above, based upon my investigation, are true.

[Signature]  
SIGNATURE OF ARRESTING OFFICER

Sworn to and subscribed to before me this 2 day of October 2022

[Signature]  
NOTARY PUBLIC / CLERK OF COURT / OFFICER (F.S.S. 117.10)

COURT

STATE ATTORNEY

CENTRAL RECORDS

JAIL

CRIME ANALYSIS

P. I. O.