SCRAM REFERRAL DIRECTIVE

Date of Referral: _______________

AGENCY INFO

Referring Agency: _______________ Referring Officer: _____________________

Officer Contact Info: __________________ E-Mail: __________________________

Preferred Method of Notification: ____

CLIENT DATA

Offender's Name: _____________________ Case Number:_____________________

Address: _____________________ City: ___________ State: ________ Zip: ________

Phone: ____________________ D.O.B.: __________ Sex: ________ Race: _________

Education Level: ________________ Preferred Language :______________________

Occupation: __________________________ Hourly Wage: ___________________

CRIMINAL BACKGROUND

Current Charges: ______________________ Prior Arrests: _____________________

Prior Convictions: ______________________ Term of Probation/Parole: ___________

Status of Driver's License: _________Valid_________Suspended__________Revoked

SCRAM CONDITIONS

Client to begin SCRAM monitoring by: __________________

Length of Program: ______________ Total Days to Complete: _______________

Other Conditions:____