

RAINN SPEAKERS BUREAU

First Name: _____ **Last Name:** _____

Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Email:** _____

Date of Birth: _____ **Female** ___ **Male** ___

How old were you when you were attacked? _____

Did you tell someone? _____

If yes, who did you tell (ex. hotline, friend, family member, teacher, etc.)?

Have you ever called the National Sexual Assault Hotline? Yes ___ No ___

Have you received counseling? If yes, please specify the type of counseling you receive such as church, school, professional, etc. _____

Was the crime reported to the police? Yes ___ No ___

If yes:

—**Was an arrest made?** Yes ___ No ___

—**Was the perpetrator convicted?** Yes ___ No ___

—**How long after your attack did the trial take place or was a plea bargain reached?**

___ Years ___ Months

Was there a forensic exam (rape evidence kit) performed? Yes ___ No ___

Were you assaulted by –

___ friend/partner ___ family member

___ acquaintance ___ stranger

Please feel free to add anything else you'd like us to know about you/your experience.

I, _____, acknowledge that the above information is true and accurate.

Signature

Date

Please mail this form, along with the following items to:

RAINN

2000 L Street NW, Suite 406

Washington, DC 20036

- a photograph of yourself
- copies of magazine articles, newspaper clippings, or videotapes of your story

If you are under the age of 18, please have a parent or guardian sign below giving you permission to participate.

Signature

Date