

Civil Harassment Restraining Order Packet

Your appointment with the legal department is scheduled for:

Date:_____ Time:_____

Please finish this packet before the day of your appointment. If your packet is unfinished, we will schedule you for a new date and time. If you need help with filling out the packet, please come to your appointment at least 30 minutes early. You can also call us at (209) 725-7900.

If you are more than 15 minutes late to your appointment, you will need to reschedule.

Please be aware that it can take up to two hours to work on your order. We know that our clients may have children; but because of how long it takes, we ask that you try to find other kinds of childcare to make this easy on you. You may bring them with you if you cannot find other childcare.

Valley Crisis Center will finish the forms to submit your temporary order. Once we take the forms to court, we have no control of how long it takes to get them signed by the judge and returned to us.

Once we do get the temporary order back from the court we will package it and call you to pick up your copies. When you do come in to pick up your order, someone will explain what the judge ordered, what you need to do next, and your court dates.

Please complete as much as possible.

Client Information (Name of Person Seeking Protection):

Name:

Address:

City: _____

State: _____ Zip Code: _____

Date of Birth: ____/____/____ Age: ____ Race: _____

Hair Color: _____ Eye Color: _____

Weight: _____ Height: _____

Gender: _____

Telephone Number: _____

Cell Phone Number: _____

Are You Requesting To Use Our Confidential Address? Yes No

Other Party Information (Person you are Seeking Protection from):

Name:

Address:

City: _____ State: _____

Zip Code: _____

Date of Birth: ____/____/____ Age: ____ Race: _____

Hair Color: _____ Eye Color: _____

Weight: _____ Height: _____

Gender: _____

Driver's License Number: _____

State Issued In: _____

Telephone Number: _____

Cell Phone Number: _____

Scars, marks, or tattoos: _____

Other Names Used by the Other Party:

Is the Other Party Employed? Yes No If yes, please complete:

Employer:

Business Address:

City: _____ State: _____

Zip Code: _____

Telephone Number: _____

Occupation/Job: _____

Work Hours:

Do you want other people who live with you protected?

Name	Age	Date of Birth	Gender	Lives With You	Relation to You
_____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

What is your Relationship to the Other Party? (How do you know them?):

Why are you filing in this county?

- The Other Party Lives in this County
- The Other Party Harassed Me in this County
- Other: _____

Have You or Any of the Additional Protective Persons Been Involved In Any

Other Court Cases: Yes No Unsure

If yes, the case type: _____

What County, Year Filed And Case Number:

County: _____ Case Number: _____

Year: _____

Are there now any protective orders in effect relating to you or any of the additional protective people and the Other Party? Yes No

Would You Like To Have Any Animals Protected In This Order? Yes No

Please List:

Do you have any additional requests or orders? Yes No If Yes, Describe:

How Are You Going To Have The Other Party Served With The Temporary Restraining Order?

Merced Sheriff's Department

Friend/Family Member who is 18 years or older and not on the order

Is the victim a Minor? Yes No

If yes, would you like the case to be kept confidential from the public?

Yes No

Will you need interpreter assistance at court? Yes No

A Civil Harassment Restraining Order Protects People From Abuse.

It is important that you complete the next three pages with as much detail and as accurate as possible from the incidents only. If you need additional room, please use the back of the packet.

Most Recent Incident of Abuse

Date of Most Recent Abuse: _____

Who Was There?

How did the Other Party harm/harass you?

Did the Other Party use a Gun or Other Weapon? Yes No

If yes, explain:

Were you harmed or injured because of the incident? Yes No

If yes, explain:

Did The Police Come? Yes No

If Yes, Did You Receive An Emergency Protective Order? Yes No

Case Number: _____ Date of Order: _____

Expiration Date: _____

Additional Information:

Has the Other Party Ever Done the Following?

(Check all that they have done to you)

- | | | |
|---|--|---|
| <input type="checkbox"/> Slapped | <input type="checkbox"/> Twisted Arm | <input type="checkbox"/> Criticizes How You Look |
| <input type="checkbox"/> Tried to Smother | <input type="checkbox"/> Ripped Clothing | <input type="checkbox"/> Threatens to Take Kids |
| <input type="checkbox"/> Shake | <input type="checkbox"/> Forced to Have Sex | <input type="checkbox"/> Tracks Your Time |
| <input type="checkbox"/> Bang Head | <input type="checkbox"/> Forced to
Have/Perform Oral Sex | <input type="checkbox"/> Criticizes Your
Intelligence |
| <input type="checkbox"/> Push to the Ground | <input type="checkbox"/> Forced to
Have/Perform Anal
Sex | <input type="checkbox"/> Criticizes Your Work |
| <input type="checkbox"/> Bite | <input type="checkbox"/> Spit in Face | <input type="checkbox"/> Criticizes Your
Housework |
| <input type="checkbox"/> Grabbed | <input type="checkbox"/> Pulled Hair | <input type="checkbox"/> Prevents you from seeing
Family |
| <input type="checkbox"/> Squeezed | <input type="checkbox"/> Wrestled | <input type="checkbox"/> Criticizes Parenting Skills |
| <input type="checkbox"/> Kicked | <input type="checkbox"/> Pinned Down | <input type="checkbox"/> Prevents You From
Activities |
| <input type="checkbox"/> Scratch | <input type="checkbox"/> Tied Up | <input type="checkbox"/> Threatens to Kill You |
| <input type="checkbox"/> Abused the
Children | <input type="checkbox"/> Choked | <input type="checkbox"/> Insults in Front of Others |
| <input type="checkbox"/> Hit with Objects | <input type="checkbox"/> Shoved | <input type="checkbox"/> Thrown Things |
| <input type="checkbox"/> Burned Things | <input type="checkbox"/> Punched | <input type="checkbox"/> Damaged the Car |
| <input type="checkbox"/> Broken Things | <input type="checkbox"/> Hurt Pets | |

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Injuries You Have Gotten from The Other Party:

(Check all the injuries you may have gotten from the Other Party)

- | | | |
|---|---|--|
| <input type="checkbox"/> Bruises | <input type="checkbox"/> Cuts Needing Stitches | <input type="checkbox"/> Sought Medical Care |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Sprains | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Back Injuries | <input type="checkbox"/> Burns | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Cuts | <input type="checkbox"/> Scratches | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Black Eyes | <input type="checkbox"/> Injuries from Sex | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shaking | <input type="checkbox"/> Crying | <input type="checkbox"/> Insomnia/Lack of Sleep |

Does The Other Party Call You Names?

(Please list all Names The Other Party Calls You)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____