

Schenectady Police Department

531 Liberty Street, Schenectady, NY 12305
Phone: (518) 382-5201 Fax: (518) 382-5299

www.schenectadypd.com



Wayne E. Bennett, Public Safety Commissioner Brian A. Kilcullen, Chief of Police

Patrick LeGuire
Assistant Chief of Police
Investigative Services Bureau

Jack Falvo
Assistant Chief of Police
Field Services Bureau

Michael J. Seber
Assistant Chief of Police
Administrative Services Bureau

The Schenectady Police Department encourages citizens to assist in the investigation of complaints against our officers. The statement you are about to give is necessary to complete an investigation. The Police Department takes all precautions to protect the confidentiality of citizens and statements. However, your name or the information you give may have to be revealed as part of the investigation or in conjunction with any administrative or judicial proceedings.

Once your complaint is filed it will be investigated by the Office of Professional Standards. Once the investigation is complete a written summary and finding is issued.

Your complaint will be thoroughly reviewed at various levels; the OPS Commander, Chief of Police and the Civilian Police Review Board all review and approve each case.

Internal investigations and the review of that investigation, including administering discipline when necessary, is a very time consuming process. Please be patient. At the conclusion of the process you will receive written notice of the findings.

Filing a complaint does not bar the filing of a lawsuit for damages or injury, nor does it bar prosecution for perjury or filing a false instrument.

As the Chief of Police I want to that you in advance for your cooperation and patience during this process.

Sincerely,

Brian A. Kileullen

Brian A. Kilcullen Chief of Police



Schenectady Police Department Personnel Complaint Form



	OPS Case #			
Date of Report:				
Date of Report: Time of Report:				
			SS#:	
Address:		, <u> </u>	55π.	
Phone: (H)	W)	O	ther	
=p10, -11				
Address:				
Date of Incident Complained of:		Tin	ae:	
Location of incident:				
Standard Incident Report (SIR) Nur	mber:			
Personnel Complained of: (name, bad				
Were there witnesses present? If Y	Yes: Witness Information	n: (name, age, addre	ess, phone numbers, employment)	
If	No: Check Box 🗆			
Complaint Dessived Dry Signature				
Complaint Received By: Signature:				
Printed Na	nme:			_
Where Received:				
				-
Complainants Initials:	I can read and write i	n the English L	anguage.	
Complainants Initials:				
		-6-1-1	promit proxite	
a 1: a:			_	
Complainants Signature:			Date:	



Commissioner of Deeds

Schenectady Police Department <u>Affidavit</u>

Page 1 of pages

State of New York County of Schenectady)	· · · · · · · · · · · · · · · · · · ·
City of Schenectady)	Date:
I have been informed and Misdemeanor pursuant to	I know that making a false s	tatement is punishable as a Class A aw of the State of New York.
	, being duly sworn, dep	oses and says:
Sworn to before me, this		Signed:
		Time Ended:

Affidavit Continuation

				1 agc 01_	pages
			,		
1	C	***	<i>~</i> :		
worn to before me, this day	01	_, 200	Signed:		
			Time Ended:		
Commissioner of Deeds					

OCA Official Form No: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPPA

[This form has been approved by the New York State Department of Health]

Patient Name	1 2 4 6 6 7	Birth	Social Security Number
Patient Address			I
accordance with New York State Law (IIPPA), I. Understand that: This authorization may include disclosure REATMENT, except psychotherapy no propriate line in Item 9(a). In the event eline on the box in Item 9(a), I specific If I am authorizing the release of Fobibited from disclosing such informationate the right to request a list of people of the release of ghts at (212) 480-2493 or the New Yorkecting my rights. I have the right to revoke authorization thorization except to the extent that actifunct in the conditioned upon my authorization the conditioned upon my authorization thromation disclosed under this authorization may no longer be protected by THIS AUTHORIZATION DOES N	and the Privacy Rule of the and CONFIDEN't the health informationally authorize the relective field alcohol convitation and the who may receive disclosure of HIV-related the cork City Commissionat any time by writing on has already been to atton is voluntary. My atton of this disclosure for its disclosure of this disclosure of the cork City Commissionat any time by writing on has already been to atton is voluntary. My atton of this disclosure for its disclosure for its disclosure of the cortex of the	of the Health Issuand lating to ALCOHOL TIAL HIV* RELATION described below ase of such information drug treatment, or ization unless permior use my HIV -releated information, In of Human Rights ag to the health care paken based on the aux treatment, payments. Tedisclosed by the area of the payments.	t, enrollment in a health plan, or eligibility for ben- recipient (except as noted above in Item 2), and SS MY HEALTH INFORMATION OR MEDIC
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* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Signature of patient or representative authorized by law