Date Stolen: ___/___/___
Stolen Checks ___ or
Counterfeit Checks___

Supplemental Victim Statement
Report of Stolen or Counterfeit Checks

Police Department _____ Case # _____

Date of Police Report _____/_____/_____ Police phone # and (if known) contact person _____

REPORTING VICTIM INFORMATION

Name _____ Date of Birth ____/___/_____
First Middle Last *MM DD YY*

Address _____ City/State/Zip _____

Daytime Phone _____ Evening Phone _____

Exact name(s) on reported checks _____

_____

Exact address on reported checks _____

Exact city,state,zip on reported checks _____

Was your driver license or state issued identification stolen? ☐ Yes ☐ No

If YES what was the state of issue and the number? _____ _____
State ID numbers, such as MN 230-230-330-330

FINANCIAL INSTITUTION (BANK OR CREDIT UNION) INFORMATION FROM REPORTED CHECKS

Wings Financial Credit Union
14985 Glazier Avenue
Apple Valley, MN 55124
952-997-8220

Routing # 296076152

Credit Union Account # _____

Use FULL number from the bottom of reported checks - please print with spacing exactly as it appears on check.

VICTIM'S ACKNOWLEDGEMENT

I understand that making a false statement is subject to federal and/or state statutes and may be punishable by fines and/or imprisonment.
I understand that making a false report to a police officer is a criminal misdemeanor offense.

As an owner of the account, I agree to hold law enforcement agencies, retailers, banks, credit unions, check authorization services or any reporting association harmless from any personal injury, loss, or general liability, for refusing to accept the reported stolen checks. I understand that I am responsible for immediately closing this checking account by contacting my financial institution and that checks that have been written on the account may not be accepted by anyone for goods or services. I understand that I must cooperate with merchants and businesses that may have accepted checks in good faith. I agree to complete the required affidavits of forgery and may be asked to file additional police reports.

Please acknowledge by checking the boxes to indicate you understand and will comply with each of the following statements (**must affirm** by indicating **yes** to each):

Yes ☐ No ☐ I am an authorized owner / signer on the described account according to the records of my financial institution.
Yes ☐ No ☐ I agree to immediately contact my financial institution and ask them to close the affected checking account.
Yes ☐ No ☐ I will notify all authorized signers of the closing of this checking account to avoid any embarrassment to them.
Yes ☐ No ☐ I understand that completing this form does not protect me from any check loss.
Yes ☐ No ☐ I understand that the information on this form will be used as a public service to victims.
Yes ☐ No ☐ I understand this document is a public record available to law enforcement agencies, financial institutions, merchants and all businesses including hotels, restaurants, and casinos etc.
Yes ☐ No ☐ I agree to hold harmless the companies this information is released to if they refuse to accept checks drawn on this account.
Yes ☐ No ☐ I voluntarily authorized the release of this information and understand I will need to contact my bank or credit union to ensure that any and all valid checks outstanding are properly paid.

_____ _____
Signature of account owner (required) *Date*

_____ _____
Signature of account co-owner (if available, optional signature) *Date*

Police Department or Victim can fax to 651-304-1489 – for distribution of this public record to retailers and financial institutions indicated on back.
If mailing please send to: FRPA, PO Box 41601, Plymouth, MN 55441.

RETAIN A COPY OF THIS FORM. INFORMATION CANNOT BE CANCELLED AFTER BEING COMMUNICATED!!