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County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

1600 PACIFIC HIGHWAY, STE. 251, SAN DIEGO, CA 92101
TELEPHONE: (619) 238-6776
FAX: 1 (619) 894-8310
www.sdcounty.ca.gov/clerb

To Whom It May Concern:

Thank you for contacting the Citizens' Law Enforcement Review Board. The Citizens' Law Enforcement Review Board (CLERB) was established to receive, review and investigate citizen complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department which allege: (A) use of excessive force; (B) discrimination or sexual harassment in respect to members of the public; (C) the improper discharge of firearms; (D) illegal search or seizure; (E) false arrest; (F) false reporting; (G) criminal conduct; or (H) misconduct. You can review our website and the attached brochure for further specific information regarding our process.

Please read this page and the instructions on the forms that follow carefully before completing them.

In order for the Review Board to open an investigation, a complaint must be signed under penalty of perjury. Please print, complete, sign and return the **Complaint Form** including the "**Complainant Information**" and "**Incident Information**" sections of the form. If the complaint involves allegations of injury, please complete and return the **Authorization To Use Or Disclose Protected Health Information** medical release form(s).

You may mail or fax the completed forms to the above-listed address or facsimile number. You may also scan the documents and email it to www.sandiegocounty.gov/clerb. If you are unable to complete or print the above-listed forms or prefer to type your complaint, you may email your complaint with a mailing address; staff will copy your complaint into the required forms and mail them to you for your review, signature, and return.

The Review Board has jurisdiction over complaints alleging misconduct in the performance of duty by peace officers employed by the Sheriff's and Probation departments. The Review Board also has jurisdiction over deaths that occur in connection with the actions of these peace officers. The Review Board does not have jurisdiction over non-specific complaints about jail conditions, or over the conduct of civilian employees, such as medical and clerical staff, of the Sheriff's and Probation departments. All complaints must be received within one year of the incident that gave rise to the complaint unless the complainant was incarcerated or incapacitated during that year. Additional information about the Review Board is available on our website.

If you have any questions, please contact us in writing (U.S. mail or email), by phone at (619) 238-6776, or in person at the above-listed address.

Sincerely,
The Citizens' Law Enforcement Review Board

**SAN DIEGO COUNTY
CITIZENS' LAW ENFORCEMENT REVIEW BOARD**

INSTRUCTIONS FOR COMPLETING CITIZEN COMPLAINT FORM

Please describe, in detail, the event(s) that led to this complaint. Be as clear and specific as possible. If you do not know the name(s) or identification numbers(s) of involved Sheriff's deputies or Probation officers, provide as much descriptive information as possible. Include the date, time, and location of the event(s). List any witnesses and their contact information. If you need more space, attach additional sheets.

Your statement must be a true and accurate account of the incident to the best of your knowledge, and you must sign and attest to its truthfulness under penalty of perjury. If you have questions or need help, please call the Review Board at (619) 238-6776, or leave a message at that number after hours or on holidays.

In accordance with the County Administrative Code, a copy of every signed complaint received by the Review Board is sent to the Sheriff or Chief Probation Officer. Investigative materials are confidential and are not disclosed to the public, including complainants, unless compelled by court order pursuant to California law.

Staff strives to complete every investigation within one year of receipt of a signed complaint; death and complex investigations may take longer to complete. Because the investigative process can take several months, please notify the Review Board of any changes in your contact information. Failure to maintain contact information or failure to cooperate in the investigation will result in a recommendation to the Review Board for Summary Dismissal. You will be notified in writing of the date the Review Board will consider your complaint in closed session and its decision.

INSTRUCCIONES

Por favor describa, en detalle, el evento o los eventos que generan esta queja. Sea lo más claro y específico posible. Si usted no sabe el nombre o placa del oficial o de los oficiales involucrados, provéanos con toda la información descriptiva posible. Si necesita mas espacio, anexe hojas de papel adicionales.

Su declaración debe de ser clara y debe proveer una descripción detallada del incidente de acuerdo a su conocimiento del mismo. Además, debe firmar este documento bajo pena de perjurio. Si usted tiene preguntas o necesita ayuda, por favor contacte a un investigador del Consejo de Revisión al número (619) 238-6776, o deje un mensaje si llama después de las horas de trabajo, o en días festivos.

De acuerdo al Código Administrativo del Condado, copias de las quejas recibidas por el Consejo de Revisión serán enviadas al Departamento del Alguacil. Con excepción de lo que este permitido por ley, los materiales de la investigación son considerados confidenciales y no estarán disponibles al público, incluyendo los querellantes.

Nos esforzamos en completar cada investigación dentro del primer año de recibida. Debido a que el proceso de investigación puede tomar varios meses, por favor notifique al Consejo de Revisión cualquier cambio en su dirección y numero de teléfono. A usted se le notificara por escrito le fecha en que su caso será considerado por el Consejo de Revisión y la decisión tomada.

COMPLAINANT INFORMATION

| | | | |
|---|------------|------|---------------|
| COMPLAINANT NAME | | | |
| MAILING ADDRESS | | | |
| PHONE # (Home & Work) | | | |
| EMAIL | | | |
| SEX: | ETHNICITY: | DOB: | DL, ID or BK: |
| NAME & ADDRESS OF AGGRIEVED (If other than complainant) | | | |
| IF IN CUSTODY, FACILITY & DATE OF RELEASE | | | |
| OUT OF CUSTODY ADDRESS & PHONE | | | |

| INCIDENT INFORMATION | |
|------------------------------------|--|
| LOCATION OF INCIDENT | |
| DATE OF INCIDENT | RACE OR GENDER ISSUE? <input type="checkbox"/> |
| ACCUSED NAME, BADGE # & ASSIGNMENT | |
| WITNESS NAME, ADDRESS, PHONE # | |

| HOW DID YOU LEARN ABOUT CLERB? | | | | | | |
|--------------------------------|----------------------------|---------------------------|----------------------------|---------------|--------------------------|----------------------------|
| Other Citizen/Inmate | Prior Complainant/ Witness | Other Department Referral | CLERB Information Brochure | CLERB Website | Other Public Information | Unknown/ Declined to State |
| | | | | | | |

PLEASE GO TO NEXT PAGE>>>>>

| CLERB STAFF USE ONLY | | | | | | |
|---|--------------------------------------|---|--------------------------|--|--|--|
| LODGE DATE | | FILE DATE | | CASE NUMBER | | |
| INTAKE INV | | HOW RECEIVED | | | | |
| INJURIES CLAIMED <input type="checkbox"/> | | INJURIES VISIBLE <input type="checkbox"/> | | DRUG OR ALCOHOL RELATED <input type="checkbox"/> | | |
| MEDICAL RELEASE SIGNED <input type="checkbox"/> | | PHOTOS TAKEN <input type="checkbox"/> | | OTHER WAIVERS SIGNED <input type="checkbox"/> | | |
| ALLEGATIONS | | | | | | |
| <input type="checkbox"/> | Excessive Force (EF) | | <input type="checkbox"/> | Discrimination or Sexual Harassment (DC) | | |
| <input type="checkbox"/> | Improper Discharge of Firearms (IDF) | | <input type="checkbox"/> | Illegal Search or Seizure (ISS) | | |
| <input type="checkbox"/> | False Arrest (FA) | | <input type="checkbox"/> | False Reporting (FR) | | |
| <input type="checkbox"/> | Criminal Conduct (CC) | | <input type="checkbox"/> | Misconduct (M) | | |
| <i>Misconduct Sub-categories:</i> Discourtesy Harassment Intimidation Medical Procedure Retaliation Truthfulness | | | | | | |
| STAFF COMMENTS | | | | | | |
| | | | | | | |

(Attach additional sheets. Number pages as needed and sign bottom of each added page.)

SWORN STATEMENT OF COMPLAINANT: I hereby certify that, to the best of my knowledge, and under penalty of perjury, the statements made herein are true.

Date

| | | |
|--|------------|------|
| SWORN STATEMENT OF COMPLAINANT: I hereby certify that, to the best of my knowledge, and under penalty of perjury, the statements made herein are true. | | |
| Signature | Print Name | Date |
| | | |

COUNTY OF SAN DIEGO / CLERB #

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize disclosure of my health information to:
The Citizens' Law Enforcement Review Board (CLERB)
1600 Pacific Highway, Ste. 251, San Diego, Ca 92101
Telephone: (619) 238-6776 FAX: 1 (619) 894-8310
www.sdcounty.ca.gov/clerb

COMPLAINANT

NAME:

STREET:

CITY/STATE:

ZIP:

TELEPHONE:

ALIAS:

DOB:

DISCLOSURE IS REQUIRED BY THE FOLLOWING INDIVIDUAL(S) OR ORGANIZATION(S):

MEDICAL PROVIDER: SHERIFF'S MEDICAL RECORDS AND/OR

DATE OF SERVICE:

ADDRESS:

CITY/STATE:

ZIP:

TELEPHONE:

FAX:

I UNDERSTAND THAT REFUSAL TO PROVIDE AUTHORIZATION DOES NOT PROHIBIT, BUT MAY PREVENT A THOROUGH INVESTIGATION OF MY COMPLAINT. THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

☒ Complete Record ☐ Other / Provide Description:

(The Requestor may use the medical records and type if information authorized for the CLERB Investigation ONLY)

Expiration: This authorization will expire upon completion of the investigation or within one (1) calendar year from the date the complaint was signed. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to file a complaint with CLERB. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in section 45 CFR 164.524. I have right to receive a copy of this authorization by the medical provider. I would like a copy of this authorization. ☐ Yes ☐ No

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: CLERB will not re-disclose my health information without my written authorization.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

I agree that a photocopy or faxed copy of this authorization shall be valid as the original.

SIGNATURE:

DATE:

LEGAL REPRESENTATIVE (Please include relationship to the complainant):