**FEDERAL IMMIGRATION ENFORCEMENT INCIDENT REPORTING FORM**

Contact Name:

Hospital Name:

Phone Number:

Address:

**When filling out this form, please do not submit personal information for the individuals involved including immigration status.**

**Please submit this form to the Attorney General’s Civil Rights Office at** [**civilrights@oag.state.md.us**](mailto:civilrights@oag.state.md.us)**. Contact the office at 410-576-6300 (888-743-0023 –toll free)**

1. Date and Time of Incident:
2. Location of Incident Within the Hospital:
3. Name of Agency and Involved Officials:

1. Information Requested by the Involved Agency:
2. Was the involved individual a patient? If not, please provide the reason for why the individual was in the facility.
3. Did the official or agency provide documentation? Please attach and submit with this form.
4. Facility Response and Outcome: