SUSPECT
INSTRUCTIONS
DoD SEXUAL ASSAULT EVIDENCE COLLECTION KIT AND DD FORM 2911

FOR MEDICAL PERSONNEL
BEFORE YOU BEGIN

Purpose of this Kit

- The following instructions have been written to assist the examining healthcare provider in the collection of evidentiary specimens from a SUSPECT using the DoD Sexual Assault Evidence Collection Kit.

Sexual Assault is not a Medical Diagnosis

- You are not requested nor encouraged to analyze any of the specimens/evidence collected in this kit. While sexual assault is a medico-legal health concern, whether or not such a crime occurred is a matter for the court to decide. The healthcare provider should not express conclusions, or opinions of diagnosis to the suspect or others, nor should any such opinions be written in the record.

Marking items for SUSPECT Examinations

- When filling out clothing bag labels, evidence envelopes, and the top of the kit box, ALWAYS mark out the word "Victim" and circle the word "SUSPECT" on the label.
- Many kit items have labels to fill out. Ensure that each item is labeled completely. If no sample was collected using a kit item, check "no" on the label and indicate the reason. Return all items to the kit, whether used or not.

Steps to conduct in a SUSPECT Sexual Assault Forensic Examination:

- If the assault occurred ***within the last 72 hours***, follow ***all*** Steps listed below.
- If the assault occurred ***more than 72 hours ago,*** follow Steps A, C, D and E through H ***only***.
- NOTE: Attempt to collect evidence regardless if the criminal investigator knows that the suspect has bathed and changed clothes since the assault.

Required Use of DD Form 2911:

- The Department of Defense requires that every healthcare provider who conducts a sexual assault medical forensic examination in a MTF must use a standard form to record findings.
- Complete this report in its entirety. Use N/A (not applicable) when appropriate to indicate that an item was read but not inadvertently skipped.
- Numbered paragraphs in these instructions correspond to the numbered blocks within the lettered sections on DD Form 2911.

Modifying Kit Contents for Suspect Exam:

- The kit contents have been updated and no longer require that items be discarded for a Suspect examination. Example - If "Step 3 - Bra Bag" is not indicated for use write "Not Used" across the label and return to the kit.

Other Considerations:

- The healthcare provider conducting the examination should note on the DD Form 2911 the source of authorization ("consent" or "search authority") before the examination proceeds (See detailed instructions in STEP A below).
- **The original, completed DD Form 2911 should be kept with the Sexual Assault Forensic Examination kit, in the storage compartment on the exterior of the box.** Should the kit be sent to the laboratory for analysis, a copy of the DD Form 2911 must accompany the kit.
- Criminal investigators should be present in the room during a suspect examination. This is to ensure the safety and security of all parties involved.

FORM INSTRUCTIONS FOR SUSPECT

STEP A: OBTAINING GENERAL INFORMATION, RECEIVING EXAMINATION AUTHORITY, AND MODIFYING THE KIT FOR SUSPECT USE (DD Form 2911, Part 1, Sections A-D)

Fill Out Patient Identification Block at the Top of Each Page of DD Form 2911:

- Enter the suspect's full name in the block. Enter "Suspect" under the name.

DD FORM 2911, SECTION A. GENERAL INFORMATION: Print or type the name of the facility where the examination was conducted.

1. Name of Suspect. Enter the suspect's full name in the appropriate blocks.
2. Address. Enter the suspect's address and telephone number only if required by requesting agency.
3. Demographics. Enter the suspect's age, date of birth, sex, race and ethnicity.
4. Arrival Date. Enter the date / time of arrival to facility.
5. Discharge Date. Enter the date / time of discharge from facility.

DD FORM 2911, SECTION B. NOTIFICATION AND AUTHORIZATION. Enter "N/A" into the boxes indicating the jurisdiction where the incident(s) occurred and the name of the assisting agency.

1. Enter "N/A" in SARC information blocks 1a and 1b.
2. Enter the name, rank, title and telephone number of the Sexual Assault Forensic Examiner (the trained, qualified healthcare provider conducting this examination).
3. Enter "N/A" in Victim Advocate information blocks 3a and 3b.
4. Enter the name, telephone, agency and identification number (e.g., badge or employee number, if available) of the investigator from the Military Criminal Investigative Organization (MCIO) (e.g., Army CID, NCIS, AFOSI). The completed kit and documentation must be turned over to one of these agencies.
5. Place "N/A" in the Evidence Collecting Officer blocks 5a through 5g.

DD FORM 2911, SECTION C. REPORTING INFORMATION. Cross out all of Section C and write "N/A" across the area.

DD FORM 2911, SECTION D. PATIENT CONSENT. Cross out blocks 1 through 8 and write "N/A" across the area. In block 9a, Patient Signature, enter "CONSENT" for examinations in which the suspect has granted consent, or "SEARCH AUTHORITY" for examinations in which an appropriate authority has granted authority to proceed or issued a search warrant. Cross out the remaining sections of the page (Blocks 10 and 11), and write "N/A" across those areas.
NOTE: Obtaining consent or search authority for a suspect examination is the responsibility of the criminal investigator, not the healthcare provider.

- **Consent** for the examination will be documented on a separate form that is signed by the suspect and kept by the criminal investigator. The criminal investigator is required to show this completed consent form to you, prior to starting the examination.
- **Search authorization** for the examination is documented on a separate form that is kept by the criminal investigator. The search authorization form, signed by an appropriate authority, should be shown to you prior to starting the examination. However, criminal investigators may not always have a completed search authorization form at the time of the exam, as they are also allowed to obtain verbal search authority in certain circumstances. When a signed search authorization is not available, a criminal investigator should inform you of the identity of the authority granting verbal search authorization and the date/time that the authorization was granted, prior to starting the examination.
- **Document** that you were made aware of the authority in block 9a or an adjacent space on the DD Form 2911.

DD FORM 2911, SECTION E. PATIENT HISTORY. Cross out all of Section E and write "N/A" across the area.

DD FORM 2911, SECTION F. ASSAULT HISTORY. Cross out all of Section F and write "N/A" across the area.

DD FORM 2911, SECTION G. PATIENT'S DESCRIPTION OF THE ASSAULT. Cross out all of Section G and write "N/A" across the area.

DD FORM 2911, SECTION H. ACTS DESCRIBED BY THE PATIENT. Cross out all of Section H and write "N/A" across the area.

STEP B: GENERAL PHYSICAL EXAMINATION, FOREIGN MATERIAL AND CLOTHING COLLECTION

Record all findings using diagrams, the legend provided, and a consecutive numbering system. Photograph all injuries described, remarkable findings, or other signs of possible trauma. Keep a log of all photographs taken (See DD Form 2911, Section Q). Also photograph non-acute injuries or signs of chronic illness that may be mistaken for injuries whenever present; annotate these on the diagrams as well.

DD FORM 2911, SECTION I. GENERAL PHYSICAL EXAMINATION.

1. Record vital signs.
2. Record the date and time the examination was started and completed.
3. Describe the patient's general physical appearance. Use observations **not** conclusions. NOTE: An observation describes physical features (e.g., dirt on left cheek, tear on right shirt sleeve, near elbow); a conclusion *renders an opinion or makes an assumption* (e.g., patient looks upset). Also describe any odors or signs of intoxicants, if present.
4. Describe the patient's general demeanor. Use observations, not conclusions.
   - Make your own observations. However, here is a recommended format for noting observed behaviors:
     - *Patient is quiet, but breaks into tears at times.*
     - *Patient wrings hands occasionally.*
     - *Patient startles when hears noises.*
     - *Patient slurs words; eyes appear bloodshot; odor of alcohol present in breath.*
5. Describe the condition of clothing upon arrival (e.g., rips, tears, presence of foreign materials). Document if investigators know if patient has changed clothes since the assault.

NOTES ON COLLECTION OF CLOTHING AND FOREIGN MATERIAL:

- Wet or damp clothing must be *air dried* before packaging.
- If the patient is not wearing the clothing worn at the time of the assault, discuss with investigators the items of clothing that should be collected during the examination.
- Do not cut through any existing holes, rips or stains in the patient's clothing.
- Do not shake out clothing, as this may dislodge microscopic evidence.
- If additional clothing bags are required than what are provided in the kit, use only new paper (grocery-type) bags (plastic bags retain moisture that can destroy or alter evidence).

6. Using the following procedures, collect the outer and under clothing requested by the criminal investigators. Use the Step 3 bags from the kit.
   - **Wear gloves.** Gloves should be changed between each step of the examination to prevent cross contamination of evidence.
   - Create a clean area for the patient to undress by placing two sheets of table paper on the floor, one overlapping the other.
   - In the Sexual Assault Exam Kit, find the bag labeled "STEP 3 FOREIGN MATERIAL." Remove the paper sheet from the bag, unfold, and place on the floor over the top of the table paper.
   - Have patient remove shoes before stepping on the paper. Instruct the patient to remove each article of clothing while standing on the paper sheet from the bag. If indicated as a source of evidence, shoes may be collected and packaged separately from clothing in a paper bag.
   - Collect each item as removed and place in the bags labeled "STEP 3 OUTER CLOTHING" (2 bags), and "STEP 3 UNDERPANTS." Package each garment in an individual paper bag, fill out the bag's label, note date/time, and seal. Be sure to cross out "Victim" and circle "Suspect" on each label. **Underpants are to be stored in the SAFE kit box.**
   - After the patient has completely undressed, instruct him or her to step off the foreign material paper sheet. Carefully fold the paper sheet into a druggist's fold (See Figure 1), being careful to keep any materials that fell off the patient in the center of the folded paper.

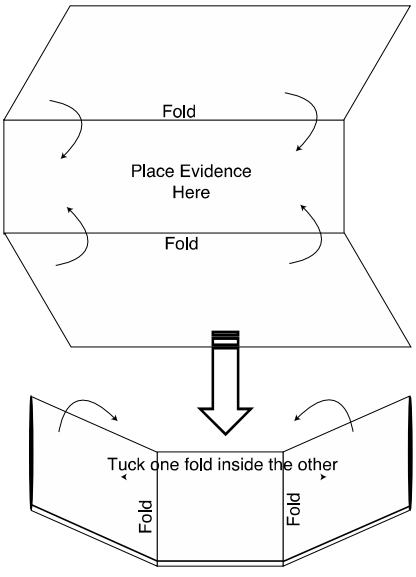

Figure 1 - Folding a Druggist's Fold

- Place the folded sheet back into the bag labeled "STEP 3 FOREIGN MATERIAL." Fill out the label of the bag, note date/time, and seal.
- In most circumstances, the table paper on the floor may be discarded at the end of the examination. If biological or other evidence falls onto the table paper, it may need to be sent to the lab for analysis, too.
- Except for the underpants, do not attempt to enclose clothing bags into the Sexual Assault Exam Kit box. Ensure the properly labeled clothing bags are provided to the criminal investigators.

STEP C: GENERAL PHYSICAL EXAMINATION (Continued) AND DEBRIS COLLECTION
DD FORM 2911, SECTION I, Blocks 7, 8, 9, and 10 (Continued from STEP B).

NOTE: FINDINGS IN SECTION I.7 AND I.8 OF DD Form 2911 MUST BE DOCUMENTED USING THE DIAGRAMS AND LEGEND PROVIDED ON THE FORM. Record size and appearance of injuries and other findings using the diagrams, the legend and a consecutive numbering system. Describe in as much detail as possible (e.g., size, shape and color of bruises). Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding (e.g., A-1, CT 2x3 cm red/purple indicates that the first finding on Diagram A is a contusion (bruise) that is 2x3 cm in size, and has a reddish purple color).

7. Conduct a general physical examination. Photograph and record all findings. Work as efficiently as possible to minimize the amount of time that the patient is undraped.
   - Change gloves now to avoid cross contaminating the patient's body with trace evidence.
   - A physical finding includes observable and palpable tissue injuries, physiologic changes, or foreign material (e.g., grass, sand, stains, dried or moist secretions, or fluorescence).
   - If no physical findings can be observed at this time, mark the "no findings observed" box.
   - Look for erythema (redness), abrasions, bruises, swelling, lacerations, cuts, bite marks, and burns.
   - Ensure that you closely examine the face, torso, arms, hands, and legs for the presence and/or absence of injury or other evidence.
   - Record all findings and evidence recovered on the diagrams and the legend on page 6. Record the locations of swab collection sites.

NOTES ON PHOTOGRAPHY AND BITE MARKS:
- Photograph injuries and other findings. Using proper forensic photographic techniques (long-range or "establishing shots", medium-range shots, and close ups).
- Use an appropriate light source and a scale near the finding (A recommended scale is depicted in Figure 3). Photograph findings with and without scale. Do not press the scale into the skin or injury.
- In order for accurate reproduction later, the plane of the film (or back of the camera) must be held parallel to the plane of the object being photographed. In other words, don't take photos at an oblique angle to the injury. Take the photograph "straight on" to the injury and fill the entire frame of the camera shot when taking close up shots (See Figure 2).
- Avoid using Polaroid and low-quality digital cameras.
- **Bite Marks.** If bite marks are present, they should be swabbed for saliva/DNA, measured, and photographed with and without a scale. Whenever possible, use an "ABFO Ruler Number 2" as a scale (See Figure 3), which allows for accurate photographic reproduction. Investigators may have one of these rulers. Bite marks can provide very specific evidence and require immediate preservation. If possible, consider calling in an experienced provider from the MTF dental clinic or a forensic odontologist to help document bite marks.

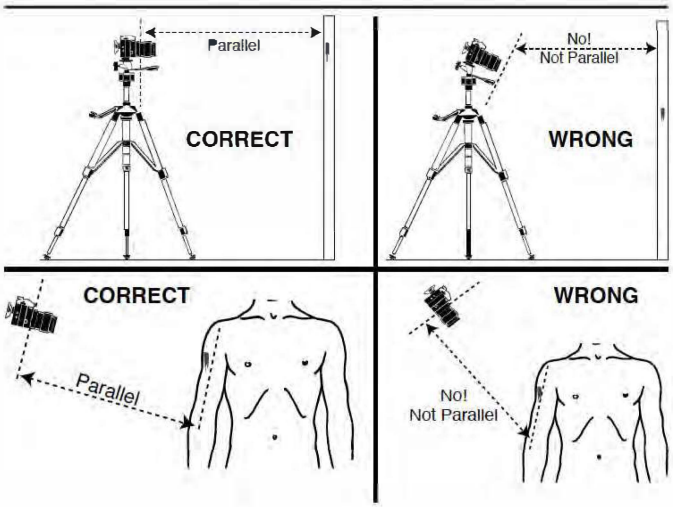

Figure 2 - Proper orientation of the camera when photographing evidence or injury

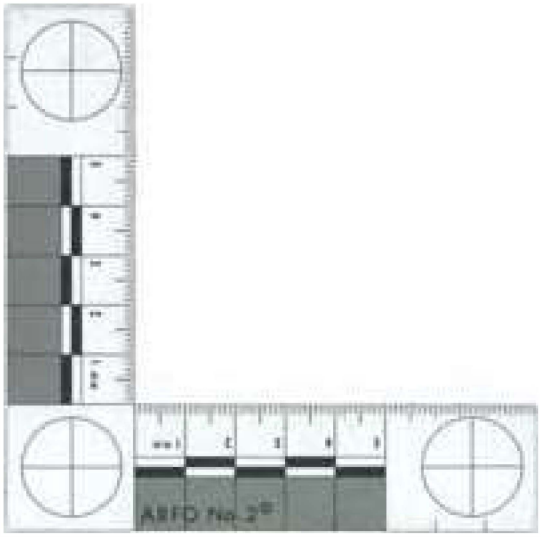

Figure 3 - American Board of Forensic Odontologists (ABFO) Ruler No. 2

Debris Collection:

- Remove folded paper sheet from the envelope labeled "STEP 4 DEBRIS COLLECTION."
- Unfold paper sheet and place on flat surface.
- Collect foreign materials such as fibers, hair, soil, sand, grass, and other forms of vegetation and place in the center of the paper sheet.
- Note location from which debris was taken on anatomical drawings on Diagrams A and B of the DD Form 2911.
- Fold paper sheet into a druggist's fold, keeping the debris in the center.
- Return the folded paper sheet to the "STEP 4 DEBRIS COLLECTION" envelope (a larger envelope may be used if necessary). Fill out the envelope label, note date/time, and seal. Be sure to cross out "Victim" and circle "Suspect" on the envelope, and seal.
- If there are several locations on the body with debris, use a clean sheet of paper and an envelope to collect debris from each area. Ensure the debris is folded into paper using a druggist's fold, and then placed in a separate envelope for each location on the body. See the front of the "STEP 4 DEBRIS COLLECTION" envelope for the information to be noted on each supplemental envelope.

8. Alternate Light Source Examination.
   - Dim the lights in the room.
   - Change gloves now to avoid cross-contaminating evidence with substances that may have gotten on the gloves during the previous portion of the examination.
   - Scan the entire body with an Alternate Light Source (such as a Woods Lamp), looking for substances that fluoresce.
   - Note fluorescent area(s) on the diagrams in DD Form 2911 and record in legend as "ALS" for Alternate Light Source.
   - Swab dried stains and/or areas that fluoresced under the ALS with a swab using the STEP 4 DRIED SECRETIONS supplies (below). Label and air dry the evidence swab(s) completely before packaging.

Dried Secretions:
- Remove swabs, swab boxes, and folded paper sheet from envelope labeled "STEP 4 DRIED SECRETIONS".
- Foreign debris such as dried semen, dried blood, dried saliva, etc., should be collected by lightly moistening the swabs provided with 1 to 2 drops of sterile water, and then thoroughly swabbing the area with the swabs.
- Swab moist secretions with a dry swab to avoid dilution. Air-dry the evidence swabs completely before packaging; do not use a heat source for drying as this may destroy evidence.
- Check off "DRIED SECRETIONS" on swab box and place swab in box. Place swab box in "STEP 4 DRIED SECRETIONS" envelope.
- Note location from which debris and dried secretions sample(s) were taken on anatomical drawings on Diagrams A and B of the DD Form 2911.

9. Fingernail Scrapings and Clippings.
   - Change gloves now to avoid cross contamination.
   - Obtain the Right and Left Hand Fingernail Scrapings envelopes from the "STEP 4 FINGERNAIL SCRAPINGS AND CLIPPINGS" envelope. Be sure to cross out "victim" on the label.
   - Remove folded paper sheet from the right hand fingernail scrapings and clippings envelope.
   - Unfold paper sheet and place on flat surface.
   - Hold patient's right hand over the paper and using the fingernail scraper provided, scrape under all fingernails allowing any debris present to fall onto paper.
   - Next, clip nails on right hand with fingernail clipper provided, letting nails fall onto the same paper (a clean nail clipper or surgical scissors may be used if none is provided in the kit).
   - Repeat above steps for left hand, using materials from left hand fingernail scrapings and clippings envelope.
   - If there is not enough fingernail to clip, swab the fingernails as part of the Finger Swab procedure below.
   - Fold the paper sheets in a druggist's fold, return them to their respective envelopes, and place those envelopes into the "STEP 4 FINGERNAIL SCRAPINGS AND CLIPPINGS" envelope.
   - Seal STEP 4 FINGERNAIL SCRAPINGS AND CLIPPINGS envelope and complete information on front.

Finger Swabs:
- If digital penetration into the vaginal/anal/oral cavity occurred during the assault or if there are insufficient fingernails to clip, collect finger swabs.
- Obtain the swabs, left hand fingers swab box, and right hand fingers swab box from the "STEP 4 FINGER SWABS" envelope.
- Lightly moisten one swab with 1 to 2 drops of sterile water, then thoroughly swab each finger to include the fingertips of the suspect's Left Hand. Set swab aside to air dry, then place in swab box labeled "Left Hand Finger Swab."
- Repeat the above procedure on the suspect's Right Hand. Set swab aside to air dry, then place in swab box labeled "Right Hand Finger Swab."
- Place swab boxes in the STEP 4 FINGER SWABS envelope. Seal and fill out all information on envelope.

10. Discuss with the investigator whether the history indicates the victim was made to kiss, lick or suck the suspect's body, other than the penis. If so, collect swabs of the corresponding parts of the body.
    - Change gloves now to avoid cross contamination.
    - Obtain swabs and swab boxes from envelope labeled "STEP 4 ORAL CONTACT".
    - Following the history provided by the investigator, swab the areas of the patient's body that suspect contacted with his/her mouth. Use a swab (or multiple swabs for large areas), moistened with a few drops of sterile or distilled water.
    - Air-dry the evidence swabs completely before packaging; do not use a heat source for drying as this may destroy the evidence.
    - Check off ORAL CONTACT on swab box and note area collected from on swab box. Place swabs in the "STEP 4 ORAL CONTACT" envelope. Seal and fill out all information on envelope.

STEP D: HEAD, NECK, THROAT AND ORAL EXAMINATION and HEAD HAIR COMBING

DD FORM 2911, SECTION J. HEAD, NECK, THROAT AND ORAL EXAMINATION. Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system. **Photograph all injuries described, remarkable findings, or other signs of possible trauma.**

Change gloves now to avoid cross contamination.

1. Examine the face, head, hair, scalp, neck, and throat for injury and foreign materials. Document findings or no findings observed.
2. If not done already, collect debris, dried and moist secretions, and foreign materials from the face, head, hair, neck, throat and scalp using procedures and materials described above in STEP C. Record findings on Diagrams, C, D, and E on DD Form 2911.
3. When indicated by history, examine the oral cavity for injury. Record findings on Diagram F on DD Form 2911.
4. Discuss with the investigators if the assault history requires collection of oral cavity swabs. Generally, oral swabs are not required from a suspect, unless the victim's biological fluids were in the suspect's mouth within four hours of this examination.
   - If this is the case, collect 2 swabs from the oral cavity using the "STEP 8 EXTERNAL MOUTH AND ORAL SWABS" envelope. Using both swabs together, carefully swab the gum line. Air-dry the evidence swabs completely before packaging; do not use a heat source for drying as this may destroy evidence. Place in swab box. Check off "ORAL" on the swab box. Fill out information on envelope with suspect name and check "ORAL" on the swab box.
   - Return swab box to "STEP 8 EXTERNAL MOUTH AND ORAL SWABS" envelope.
   - Fill out all information requested on envelope and seal.
5. Head hair combing.
   - **If suspect has head hair**, use the "STEP 5 HEAD HAIR COMBING" envelope in the kit.
   - Remove paper towel and comb provided in the Head Hair Combings envelope.
   - While the suspect is on the examination table, place towel under suspect's head.
   - Using the comb provided, gently comb head hair in downward strokes so that any loose hairs and/or debris will fall onto paper towel.
   - Carefully remove towel from under suspect's head, and place used comb in center of towel.
   - Refold towel into a druggist's fold (See Figure 1) retaining both comb and any evidence present in center of the fold and return to Head Hair Combings envelope.
   - Seal envelope and fill out all information requested on the envelope. Cross out "Victim" on the envelope and circle "SUSPECT".

NOTE: FINDINGS IN J.1, J.2 AND J.3 MUST BE DOCUMENTED USING THE DIAGRAMS AND LEGEND PROVIDED. Record size and appearance of injuries and other findings using the diagrams, the legend, and a consecutive numbering system. Describe in as much detail as possible (e.g., size, shape and color of bruises). Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding. (e.g., A-1, CT 2x3 cm red/purple indicates that the first finding on Diagram A is a contusion (bruise) that is 2x3 cm in size, and has a reddish purple color.

Note: Known head hairs and pubic hair standards are no longer routinely collected. However, gentle combing as a practice to collect foreign material is still recommended. Known hairs are collected from the individual for comparisons to questioned hairs.

STEP E: GENERAL PHYSICAL EXAMINATION (Continued) and PUBIC HAIR COMBINGS

- **If suspect has pubic hair**, use the "STEP 5 PUBIC HAIR COMBINGS" envelope in the kit.
- Remove paper towel and comb provided in the Pubic Hair Combings envelope.
- While the suspect is on the examination table, place towel under suspect's buttocks.
- Using the comb provided, gently comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto paper towel.
- Carefully remove towel from under suspect, and place used comb in center of towel.
- Refold towel into a druggist's fold (See Figure 1) retaining both comb and any evidence present in center of the fold and return to Pubic Hair Combings envelope.
- Seal envelope and fill out all information requested on the envelope. Cross out "Victim" on the envelope and circle "SUSPECT".

STEP F: GENITAL EXAMINATION and SWABS

- Cross out Section K on DD Form 2911, "Genital Examination - Female" and write "N/A" across the page.

DD FORM 2911, SECTION L. GENITAL EXAMINATION - MALE.

Blocks 1 through 3: Examine the lower abdomen, thighs, foreskin, urethral meatus, shaft, scrotum, perineum, glans, and testes (See Figure 4). Use of magnification, such as that offered by a digital camera, is recommended to help visualize and photograph injuries. If available and appropriate, toluidine blue dye may be used to help visualize injury. Document findings and use of toluidine blue dye in the diagrams and legend.

4. Skip this step, as Pubic Hair combing and collection was completed in Steps E and F, above.
5. **Penile Swabs (if assault has occurred within last 24 hours):**
   - Using the swabs provided in the "STEP 6 GENITAL SWABS" envelope, lightly moisten both swabs with 1 to 2 drops of sterile water.
   - Using both swabs simultaneously, thoroughly swab the glans and shaft of the suspect's penis.
   - Allow both swabs to thoroughly air dry, place both swabs in the swab box, and check "penile" on the side of the box.

   Scrotal Swabs (if assault has occurred within last 24 hours):
   - Using the swabs provided in the "STEP 6 GENITAL SWABS" envelope, lightly moisten both swabs with 1 to 2 drops of sterile water.
   - Using both swabs simultaneously, thoroughly swab the scrotum.
   - Allow both swabs to thoroughly air dry, place both swabs in the swab box, and check "scrotal" on the side of the box.
6. Examine and note findings of the buttocks, anus and perineum.
7. Anal swabs are not required, unless indicated by history. Cross out and mark "N/A".
8. Rectal exam and swabs are not required, unless indicated by history. Cross out and mark "N/A".
9. However, if history does indicate, use "STEP 7 ANAL/PERINEAL/ RECTAL SWABS" envelope.

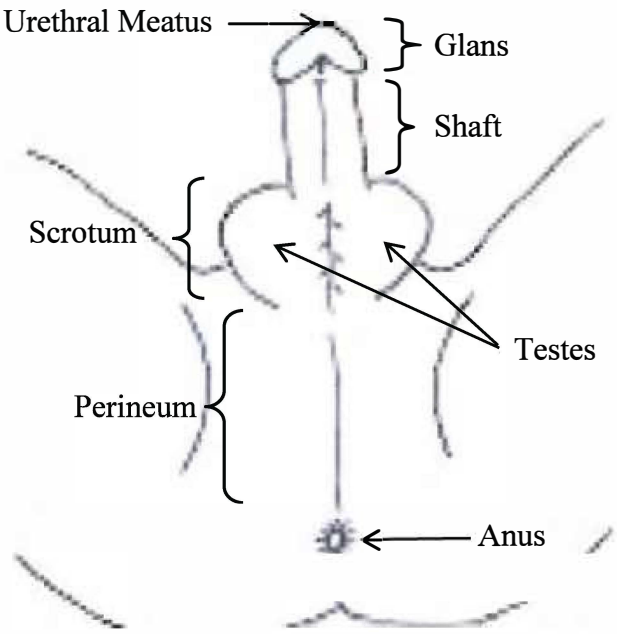

Figure 4 - Male Anatomy

NOTE: FINDINGS IN BLOCKS L.1, L.2, L.3, and L.6 MUST BE DOCUMENTED USING THE DIAGRAMS (K, L, M and N) AND LEGEND PROVIDED. Record size and appearance of injuries and other findings using the diagrams, the legend and a consecutive numbering system. Describe in as much detail as possible (e.g., size, shape and color of bruises). Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding (e.g., A-1, CT 2x3 cm red/purple indicates that the first finding on Diagram A is a contusion (bruise) that is 2x3 cm in size, and has a reddish purple color).

STEP G: KNOWN BLOOD SAMPLES - FOR DNA ANALYSIS

- Use Step 10 envelope.
- Remove the mini FTA card, auto lancet, alcohol pad, adhesive bandage and gauze.
- Stick the finger with the auto lancet and completely fill the two circles on the mini FTA card with blood.
- Dry the blood stains (approximately one (1) hour before returning the card to the Known Blood Samples envelope.
- Seal and fill out all information requested on the envelope.

ADDITIONAL STEPS:

DD FORM 2911 - SECTION M. Toxicology. DO NOT USE UNLESS SPECIFICALLY AUTHORIZED.
Toxicology samples must be collected as soon as possible due to the limited time frame in which some substances may be detected. However, seizure of body fluids for toxicological examination may not be authorized unless specifically identified on the search authority obtained by the investigators. Examinations conducted under consent may also require that the suspect be informed of the examination for illegal substances. Follow drug-testing procedures used by your MTF or the criminal investigators when collecting samples from suspects.

DD FORM 2911 - SECTION N. Record Exam Methods. Record all methods used to perform this forensic exam.

DD FORM 2911 - SECTION O. Findings. This section is a description of the findings that you documented earlier in the report. Taking all the findings as a whole, describe in as much detail as possible. **NOTE: Do not indicate if findings are consistent with sexual assault or rape. These are legal conclusions and may not be determined by the examiner.**

DD FORM 2911 - SECTION P. Evidence Collected.
- Mark "N/A" for who completed the toxicology kit.
- Document what clothing was placed in kit and/or other evidence bags, by whom, time completed, and to whom the clothing was released.
- Document all foreign material collected, by whom, time collected, and to whom foreign materials were released.
- Document who completed oral and genital samples and time completed.
- Document who completed blood card reference sample and time.

DD FORM 2911 - SECTION Q. Photo Documentation Methods.
- Document type of camera used.
- Document disposition of film/disk, e.g., who is keeping the originals (retained in kit, turned over to MCIO, etc.).
- Document photo list. Use additional sheets, if necessary.

DD FORM 2911 - SECTION R. Other Documents Included.
- List any other documents included with the report.

DD FORM 2911 - SECTION S. Personnel Involved.
- Mark "N/A" in "History Taken By".
- Name and phone number of person who performed forensic exam.
- Name and phone number of person who labeled and sealed specimens.
- Name of person(s) who assisted the examiner and their role in assistance. Attach another sheet as necessary. Be sure to include the names of anyone that assisted you in photographing or handling the evidence.

DD FORM 2911 -SECTION T. Evidence Distribution.
- Mark "N/A" in "Toxicology kit given to".
- Name of person to whom the sexual assault forensic exam kit was given, and specify the number of evidence bags provided as well.
- Document what items were returned to patient.
- Document the release of any other items of evidence and to whom they were given.

DD FORM 2911 - SECTION U. Person Receiving Evidence.
- Give to Military Criminal Investigative Organization representative (Army CID, NCIS, AFOSI).
- **Chain-of-Custody Guidelines**
  - One person at a time should be in possession of the evidence obtained during the examination.
  - Keep the number of people involved in collecting and handling samples to a minimum. Ensure all are trained properly for evidence handling.
  - If evidence is placed in a secured storage area you need to identify and document who has access to evidence.
  - Only allow people associated with the examination and/or investigation to handle samples.
- Always document the transfer of evidence from one person to another on chain-of-custody forms.
- Always accompany evidence with their chain-of-custody forms.
- Document evidence information legibly, using permanent ink.

FINAL INSTRUCTIONS

- Make sure all information requested on forms, envelopes, and bag labels has been filled out completely, and the word "Victim" has been marked out and the word "SUSPECT" has been circled, where required.
- Make copies of the DD Form 2911, and place original, signed copy in the storage area on the bottom of the kit.
- With the exception of the sealed and labeled Underpants and Outer Clothing bags, return all remaining evidence collection envelopes (used and unused) to kit box.
- NOTE: Any specimens collected for hospital use such as urine, chocolate agar plates, etc., **should not be placed in the kit.** They should be sent to the hospital laboratory for analysis or given to the criminal investigator for proper dissemination. Any specimen collected for toxicology (grey top tube) should be sent to AFIP; urine should be sent to the Service's drug testing laboratory following Service procedure.
- Initial and affix red police evidence seals where indicated on the box top.
- Fill out all information requested on the kit box top under "For Hospital Personnel", making sure to mark out the word "Victim" and circle the word "SUSPECT", then affix biohazard label where indicated.
- Hand sealed kit and sealed bags to criminal investigator. **NOTE:** If the investigator is not present at this time, place sealed kit and sealed bags in a secured area to hold for pick up.