

Date: \_\_\_\_\_

EX PARTE EXPIRATION DATE: \_\_\_\_\_

Case No.: \_\_\_\_\_

**RESPONDENT**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Suffix: \_\_\_\_\_ Aliases: \_\_\_\_\_

Driver's License: \_\_\_\_\_ Social Security: \_\_\_\_\_

Home Address or Current Residence: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Employed:  No  Yes If yes, complete the following

Business Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Hours: \_\_\_\_\_

Student:  No  Yes If yes, complete the following

School Name: \_\_\_\_\_ School Phone: \_\_\_\_\_

Address: \_\_\_\_\_ School Hours: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Distinguishing Scars, Marks, or Deformities (attach photograph, if available): \_\_\_\_\_

Has Respondent served or is Respondent presently serving in the military?

No  Yes If yes, what branch? \_\_\_\_\_

Is Respondent known to carry weapons?

No  Yes If yes, what type of weapon(s)? \_\_\_\_\_

Treatment History: \_\_\_\_\_

**PETITIONER OR PERSON TO BE NOTIFIED IN CASE OF EMERGENCY**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Suffix: \_\_\_\_\_ Relation to Respondent: \_\_\_\_\_

Address: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Please explain why you believe an Ex Parte Order is necessary for the Respondent: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_