Criminal Justice Alternatives Inc.
PO Box 724, Raleigh, NC 27602
Phone: (919) 856-5671
Fax: (919) 856-5673

Capital Area Teen Court Referral Form

Juvenile Offense: _____

Date of Referral:_____ Date of Offense:_____

Name:_____ Date of Birth:_____

Address:_____ City_____ Zip:_____

Race:_____ Gender:_____ Age:_____

School:_____ Grade:_____

Parent/Guardian(In Home) :_____ Relation:_____

Telephone Number:_____ Alternate number:_____

Email:_____

Victim:_____ Telephone Number:_____

****PLEASE ATTACH A DESCRIPTION OF INCIDENT OR POLICE REPORT****

I have read the brochure and understand the Capital Area Teen Court Program. I understand that this is a diversion program and that the youth will be assigned a reasonable and appropriate consequence for his/her action(s). I have explained the program to the youth and have given them a Capital Area Teen Court brochure explaining the program.

_____ _____ _____
Referral Source Name Phone (direct number) Date

Agency:_____ Referral Source Email: _____

SRO: NO

Revised 7/14/2020

Submit