ST. CHARLES POLICE DEPARTMENT

REQUEST FOR POLICE SERVICES

DATE SUBMITTED: _____ **Please e-mail to police@stcharlesil.gov or fax to 630.377.1578**

_____ _____
Individual Requesting Services **Home Telephone**

_____ _____
Person/Organization to be Billed **Business Telephone**

_____ _____
Address **Cell Phone**

_____ _____
City/State/Zip Code **Signature**

St. Charles PD has the authority to determine the number of officers needed based on the circumstances and conditions of the event. I hereby agree to reimburse the City of St. Charles for all compensation paid to its officers for the services and at the rates described above.

_____
Signature of Person Agreeing to Pay

TYPE OF EVENT: _____

LOCATION: _____

DATE(S)	TIME(S)	NUMBER OF OFFICERS REQUESTED
	to	
	to	
	to	
	to	

HOURLY RATE – TIME &1/2

NUMBER EXPECTED TO ATTEND _____

********** DO NOT WRITE BELOW THIS SPACE **********

APPROVED: _____ **DISAPPROVED:** _____ **DATE:** _____

Comments:_____

_____

Approved By: _____

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OFFICER SIGNUP SECTION **HOURLY RATE – TIME &1/2**

DATE	TIME	OFFICERS REQUESTED	NAME	NAME
	to			
	to			
	to			
	to			
	to			
	to			
	to			

☐ **Billing to City of St. Charles** **Verified by:** _____ **Date:** _____