

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

CASE NAME: _____

PLEASE PRINT OR TYPE

CASE NUMBER: _____

A. REPORTING PARTY	NAME OF MANDATED REPORTER		TITLE		MANDATED REPORTER CATEGORY		
	REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS		Street	City	Zip	DID MANDATED REPORTER WITNESS THE INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	REPORTER'S TELEPHONE (DAYTIME) ()		SIGNATURE		TODAY'S DATE		
B. REPORT NOTIFICATION	<input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> COUNTY PROBATION		AGENCY				
	<input type="checkbox"/> COUNTY WELFARE / CPS (Child Protective Services)		ADDRESS		City	Zip	
	DATE/TIME OF PHONE CALL		OFFICIAL CONTACTED - TITLE		TELEPHONE ()		
C. VICTIM One report per victim	NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX	
	ADDRESS			Street	City	Zip	
	PRESENT LOCATION OF VICTIM			SCHOOL		CLASS	
	GRADE			PHYSICALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		DEVELOPMENTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	OTHER DISABILITY (SPECIFY)			PRIMARY LANGUAGE SPOKEN IN HOME			
	IN FOSTER CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: <input type="checkbox"/> DAY CARE <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> FOSTER FAMILY HOME <input type="checkbox"/> FAMILY FRIEND <input type="checkbox"/> GROUP HOME OR INSTITUTION <input type="checkbox"/> RELATIVE'S HOME		TYPE OF ABUSE (CHECK ONE OR MORE) <input type="checkbox"/> PHYSICAL <input type="checkbox"/> MENTAL <input type="checkbox"/> SEXUAL <input type="checkbox"/> NEGLECT <input type="checkbox"/> OTHER (SPECIFY)	
RELATIONSHIP TO SUSPECT			PHOTOS TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		
D. INVOLVED PARTIES	VICTIM'S SIBLINGS						
	NAME		BIRTHDATE	SEX	ETHNICITY	NAME	
	1. _____		3. _____				
	2. _____		4. _____				
	VICTIM'S PARENTS/GUARDIANS	NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX
		ADDRESS			Street	City	Zip
		HOME PHONE ()			BUSINESS PHONE ()		
		NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX
	SUSPECT	ADDRESS			Street	City	Zip
		HOME PHONE ()			BUSINESS PHONE ()		
SUSPECT'S NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX		
ADDRESS			Street	City	Zip		
TELEPHONE ()			OTHER RELEVANT INFORMATION				
E. INCIDENT INFORMATION	IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX <input type="checkbox"/> IF MULTIPLE VICTIMS, INDICATE NUMBER: _____						
	DATE / TIME OF INCIDENT		PLACE OF INCIDENT				
	NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)						