

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**

Pursuant to Penal Code Section 11166

CASE NAME: _____

SAMPLE

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			Street	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	ETHNICITY			
	ADDRESS			Street	City	Zip	TELEPHONE ()			
	PRESENT LOCATION OF VICTIM			SCHOOL		CLASS	GRADE			
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER DISABILITY (SPECIFY)			PRIMARY LANGUAGE SPOKEN IN HOME				
	<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		BIRTHDATE	SEX	ETHNICITY
	1. _____					3. _____				
	2. _____					4. _____				
	VICTIM'S PARENTS/GUARDIANS	NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY		
		ADDRESS			Street	City	Zip	HOME PHONE ()	BUSINESS PHONE ()	
		NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY		
		ADDRESS			Street	City	Zip	HOME PHONE ()	BUSINESS PHONE ()	
	SUSPECT	SUSPECT'S NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY		
		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)									

SAMPLE

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