

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. _____ | |
| | 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 |
| | ADDRESS | | | Street | City | Zip |
| HOME PHONE () | | | BUSINESS PHONE () | | | |
| SUSPECT | | | | | | |
| 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) | | | | | |