

# 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: \_\_\_\_\_

<b>A. REPORTING PARTY</b>	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>B. REPORT NOTIFICATION</b>	<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 (     )			
<b>C. VICTIM One report per victim</b>	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"/> NO <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			
<b>D. INVOLVED PARTIES</b>	VICTIMS							
	SIBLINGS							
	NAME		BIRTHDATE	SEX	ETHNICITY	NAME		
	1. _____		3. _____		2. _____		4. _____	
	2. _____		4. _____					
	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'S NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY		
ADDRESS			Street	City	Zip	TELEPHONE (     )		
OTHER RELEVANT INFORMATION								
<b>E. INCIDENT INFORMATION</b>	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)							