



SUSPECTED CHILD ABUSE REPORT
(Pursuant to Penal Code section 11166)

REFERENCE NO. 822.2

[Print Form](#)

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To Be Completed by Mandated Child Abuse Reporters

PLEASE PRINT OR TYPE

CASE NAME: _____

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? | | | | | |
| | REPORTER'S TELEPHONE (DAYTIME) | | SIGNATURE | | | TODAY'S DATE | | | | | |
| B. REPORT NOTIFICATION | <input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> COUNTY PROBATION <input type="checkbox"/> COUNTY WELFARE / CPS (Child Protective Services) | | AGENCY | | | | | | | | |
| | ADDRESS Street | | City | Zip | DATE/TIME OF PHONE CALL | | | | | | |
| | OFFICIAL CONTACTED - NAME AND TITLE | | | | TELEPHONE | | | | | | |
| C. VICTIM <small>One report per victim</small> | NAME (LAST, FIRST, MIDDLE) | | | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY | | | | | |
| | ADDRESS Street | | | City | Zip | TELEPHONE | | | | | |
| | 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 | | | | | |
| | VICTIMS SIBLINGS | NAME | | BIRTHDATE | SEX | ETHNICITY | NAME | | BIRTHDATE | SEX | ETHNICITY |
| 1. | | 2. | | | | 3. | 4. | | | | |
| D. INVOLVED PARTIES <small>VICTIM'S PARENTS/GUARDIANS</small> | 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 | | | |
| SUSPECT | 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 | | | | | | | | | | | |
| 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 incident's involving the victim(s) or suspect) | | | | | | | | | | |

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code section 11169 to submit to DOJ a Child Abuse or Severe Neglect Indexing Form BCIA 8583 if (1) an active investigation was conducted and (2) the incident was determined to be substantiated.