



MANDATORY ABUSE REPORT

Date of Report:	Time:
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Name of victim/recipient/consumer (Last, First, M.I.):		Facility name:	
Address:		Address:	
City:	State:	Zip Code:	City: State: Zip Code:
Phone:		Phone:	
Date of birth:	Sex:	Facility type: (NH, PCH, DC, CLA, etc.)	
Date and time of incident: Date: / / Time: : A.M. / P.M.		Facility licensing agency:	Facility licensing number:
Date and time of report to licensing agency: Date: / / Time: : A.M. / P.M.		Licensing agency contact and telephone number: Name: Telephone # :	
<p style="text-align: center;">OAPSA (OVER 6o)</p> <p>Abuse type: (check one)</p> <input type="checkbox"/> ABUSE not Involving sexual abuse, serious bodily injury, serious physical injury or suspicious death <input type="checkbox"/> SEXUAL ABUSE (rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest) <input type="checkbox"/> SERIOUS BODILY INJURY <input type="checkbox"/> SERIOUS PHYSICAL INJURY <input type="checkbox"/> SUSPICIOUS DEATH		<p style="text-align: center;">APS (UNDER 6o)</p> <p>Abuse/Neglect type: (check one)</p> <input type="checkbox"/> ABUSE, NEGLECT, EXPLOITATION or ABANDONMENT <u>not</u> Involving sexual abuse, serious injury, serious bodily Injury or suspicious death <input type="checkbox"/> SEXUAL ABUSE (rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, or incest) <input type="checkbox"/> SERIOUS BODILY INJURY <input type="checkbox"/> SERIOUS INJURY <input type="checkbox"/> SUSPICIOUS DEATH	
Date/Time oral report to AAA: Date: / / Time: : A.M. / P.M.	Name of AAA contacted:	AAA/APS Agency use only Date/Time oral report to county coroner: (If applicable) Date: / / Time: : A.M. / P.M.	AAA/APS Agency use only Name of coroner: (If applicable)
Date/Time oral report to local law enforcement: (if applicable)	Name of law enforcement agency: (if applicable)	Date/Time oral report to PDA/DHS: (if applicable)	
Contact information: (Please check appropriate block) <input type="checkbox"/> Guardian <input type="checkbox"/> Attorney-in-fact <input type="checkbox"/> Next of kin		Alleged perpetrator name:	Relationship to victim:
Name:		Address:	
Address:		City:	State: Zip Code:
City:	State:	Zip Code:	Phone number: Age: Sex:
Phone:	Relationship:	Type of position: (RN, LPN, CNA, etc.)	Work shift: Date of hire:

PLEASE COMPLETE REVERSE SIDE

Details and description of abuse: (attach additional sheets if necessary)

Actions taken by facility, including taking of photographs and X-Rays, removal of victim and notification of appropriate authorities:
(attach additional sheets if necessary)

Other pertinent information, comments or observations directly related to alleged abuse incident and victim:

Name and title of reporter: (Please type of print)

Name:

Title:

Signature of reporter:

Reporter contact information:

Telephone number:

Email address:

Date:

Name and title of person preparing report: (Please type of print)

Name:

Title:

Signature of person preparing report:

Person preparing report contact information:

Telephone number:

Email address:

Date: