

Animal Bite Report

**STATE LAW REQUIRES COMPLETED FORM TO BE IMMEDIATELY FAXED TO (442) 265-1477
PLEASE PRINT**

Reporting Agency: _____

Person Completing Form: _____

Agency Address: _____ Time Reported: _____ AM PM

Agency Telephone: _____ Date Reported: _____

Animal Owner	Person Bitten
Name: _____	Name: _____
Address: _____	DOB: _____
City: _____	Address: _____
Telephone 1: _____	City: _____
Telephone 2: _____	Telephone 1: _____
Animal	Telephone 2: _____
Species: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other: _____	If a minor, Parent or Legal Guardian: _____
<input type="checkbox"/> Wild <input type="checkbox"/> Pet, Name: _____	Exposure
Breed: _____ Age: _____ Color: _____	Site where bite occurred: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Altered <input type="checkbox"/> Unknown	Address: _____
Behavior: <input type="checkbox"/> Unknown <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, (Explain): _____	City: _____
Current Rabies vaccination?	Telephone: _____
<input type="checkbox"/> Yes (Expiration Date): _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of Bite: _____
Current license?	Time of Bite: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Yes (Tag Number): _____ <input type="checkbox"/> No	How bite occurred: _____
Quarantine	_____
If NOT quarantined: <input type="checkbox"/> Died <input type="checkbox"/> Killed <input type="checkbox"/> Not Located	_____
If quarantined, date: _____	_____
<input type="checkbox"/> Home <input type="checkbox"/> Shelter <input type="checkbox"/> Other Location: _____	Provoked? <input type="checkbox"/> No <input type="checkbox"/> Yes
Quarantining Officer Name: _____	Wound Care
Quarantining Officer Signature: _____	Location of wound: _____
Quarantining Officer Agency: _____	Wound: <input type="checkbox"/> Skin broken <input type="checkbox"/> Severe <input type="checkbox"/> Skin NOT broken
Date of Release: _____	Sought medical treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No
Released By: _____	Doctor Name: _____
Condition of Animal on Release: _____	Doctor Telephone: _____
Comments	

