REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT

Michigan Family Independence Agency

INSTRUCTIONS:
REFERRING PERSON: Complete items 1-20. Send PART I to local County Family Independence Agency where the child is found. Retain PART 2 for your records. See additional instructions on back.

1. Date

2. List of Child(ren) Suspected of being Abused or Neglected (List additional children on back of Part 1)

NAME	BIRTH DATE	SOCIAL SECURITY #	SEX	RACE
3. Father's Name				
4. Mother's Name				

5. Name of Alleged Perpetrator of Abuse or Neglect		6. Relationship to Child(ren)	
7. Child(ren)'s Address (No. & Street)	8. City	9. County	10. Phone No.
11. Person(s) the Child(ren) Living with when Abuse / Neglect Occurred	12. Address, City & Zip Code where abuse / neglect occurred		

13. Describe injury or Conditions and Reason for Suspicion of Abuse or Neglect

14. Source of Referral (Check appropriate box)

- ☐ PHYSICIAN
- ☐ MEDICAL EXAMINER (Coroner)
- ☐ DENTIST/DENTAL HYGIENIST
- ☐ NURSE
- ☐ EMERGENCY MEDICAL SERVICES PERSONNEL
- ☐ AUDIOLOGIST
- ☐ SOCIAL WORKER
- ☐ SCHOOL ADMINISTRATOR
- ☐ SCHOOL COUNSELOR
- ☐ PSYCHOLOGIST
- ☐ PROFESSIONAL COUNSELOR
- ☐ TEACHER
- ☐ LAW ENFORCEMENT OFFICER
- ☐ CHILD CARE PROVIDER
- ☐ HOSPITAL
- ☐ MARRIAGE/FAMILY THERAPIST
- ☐ FIA FACILITY
- ☐ DCH FACILITY
- ☐ OTHER (Specify below)

15. Referring Person's Name	16. Name of Referring Organization (school, hospital, etc.)		
17. Address (No. & Street)	18. City **Ann Arbor**	19. State **Michigan**	20. Phone No.

TO BE COMPLETED BY MEDICAL PERSONNEL WHEN PHYSICAL EXAMINATION HAS BEEN DONE

21. Summary Report and Conclusions of Physical Examination

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22. Laboratory Report	23. X-Ray
24. Other (specify)	25. History or Physical Signs of Previous Abuse / Neglect YES NO

26. Prior Hospitalization or Medical Examination for this Child

DATES	PLACES

27. Physician's Signature	28. Date	29. Hospital (if applicable)

The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability. If you need help with reading writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA Office in your county.

AUTHORITY: P.A. 238 OF 1975.
COMPLETION: Mandatory.
PENALTY: None.

INSTRUCTIONS

GENERAL INFORMATION:
This form is to be completed as the written follow-up to the oral report required in the above Sec. 3. (1) Act. No. 238, P.A. of 1975, as amended and mailed to the local county Family Independence Agency. Referring person is to fill out as completely as possible items 1-20. Only medical personnel may complete items 21-29.

1. Date – Enter the date the form is being completed.

2. List child(ren) suspected of being abused or neglected – Enter available information for the child(ren) believed to be abused or neglected.

3. Father's name – Enter father's name (or father substitute) and other available information.

4. Mother's name – Enter mother's name (or mother substitute) and other available information.

5. Name of alleged perpetrator of abuse or neglect – Indicate person(s) suspected or presumed to be responsible for the alleged abuse or neglect.

6. Relationship to child(ren) – Indicate the relationship to the child(ren) of the alleged perpetrator of neglect or abuses, i.e. parent, grandparent, babysitter.

7. Child(ren)'s address – Enter the address of the child(ren).

8. City – Self explanatory

9. County – Self explanatory

10. Phone – Enter phone number of the household where child(ren) resides.

11. Person(s) child(ren) living with when abuse/neglect occurred – Enter name(s).

12. Address where abuse / neglect occurred – Self explanatory.

13. Describe injury or conditions and reason of suspicion of abuse or neglect – Indicate the basis for making a report and the information available about the abuse or neglect.

14. Source of referral – Check appropriate box noting professional group or appropriate category
    Note: If abuse or neglect is suspected in a hospital, check hospital.

    FIA Facility – Refers to any group home, shelter home, halfway house or institution operated by the Family Independence Agency.

    DCH Facility – Refers to any institution or facility operated by the Department of Community Health.

15. Referring person's name – Enter your name if you are referring or reporting this matter.

16. Name of referring organization – Enter the name of the agency or organization, if appropriate.

17. Address – Self explanatory

18. City – Self explanatory

19. State – Self explanatory

20. Phone Number – Self explanatory