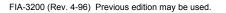
## REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT

Michigan Family Independence Agency

| NSTRUCTIONS: 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       |       |  |
|---|------------------|--|--|---------------|-------|--|
| List of Child(ren) Suspected of being Abused or Neglected (     NAME  |                  | Part 1)<br>  BIRTH DATE  | SOCIAL SECURITY #  | SEX           | RACE  |  |
| NAME  |                  | DIKTITUATE   | SOCIAL SECONTT #   | JLX           | IVACL |  |
|   |                  |  |  |               |       |  |
|   |                  |  |  |               |       |  |
|   |                  |  |  |               |       |  |
|   |                  |  |  |               |       |  |
|   |                  |  |  |               |       |  |
| 3. Father's Name  |                  |  |  |               |       |  |
| 4. Mother's Name  |                  |  |  |               |       |  |
| Name of Alleged Perpetrator of Abuse or Neglect   |                  |  | 6. Relationship to Child(ren)  |               |       |  |
|   |                  |  |  | L 40 Phone N  |       |  |
| 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 □ SCHOOL COUNSELOR  |                  | ☐ HOSPITAL   |  |               |       |  |
| ☐ EMERGENCY MEDICAL SERVICES PERSONNEL ☐ PSYCHOLOGIST  15. Referring Person's Name  |                  | □ MARRIAGE/FAMILY THERAPIST  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 W  |                  |  |  |               |       |  |
| 21. Summary Report and Conclusions of Physical Examination  |                  | MILITITIONAL LA  | CAMINATION HAS DI  |               |       |  |
|   |                  |  |  |               |       |  |
|   |                  |  |  |               |       |  |
| 22 Laboraton, Poport  |                  | 1 22 V Pay   |  |               |       |  |
| 22. Laboratory Report  24. Other (specify)  |                  | 23. X-Ray  |  |               |       |  |
|   |                  | 25. History or Physical Signs  | · ·  |               |       |  |
| 26. Prior Hospitalization or Medical Examination for this Child   |                  | YES  | NO   |               |       |  |
| DATES   | ACES             |  |  |               |       |  |
|   |                  |  |  |               |       |  |
|   |                  |  |  |               |       |  |
| 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 |                  | co   | AUTHORITY: P.A. 238 OF 1975.  COMPLETION: Mandatory.  PENALTY: None. |               |       |  |



INCLUDES CERTIFIED SOCIAL WORKER, SOCIAL WORKER, SOCIAL WORK TECHNICIAN (Act No. 352, P.A. of 1972, as amended)

## 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