



INSTRUCTIONS: Any physician, and any other medical person in the healing arts including any person licensed to render services in medicine, osteopathy, dentistry, any intern, resident, nurse, medical examiner, school employee, social worker, psychologist, or any other person who knows or in good faith suspects child abuse or neglect shall make an oral report to the Report Line using the number at the top of this page in accordance with 16 Del. C, § 903 and 904.

With 72 hours after the oral report, send a completed Child Abuse/Neglect Mandatory Reporting Form to the following address: Please type or print the information and sign the form on the back.

DIVISION OF FAMILY SERVICES – STATE OF DELAWARE

3601 North Dupont Highway New Castle, DE 19720-6315

IDENTIFYING INFORMATION

Child's Name (Last, First, Initial) Date of Birth/ Age Sex Race Victim (Yes/No)

1.

Current Address:

2.

Current Address:

3.

Current Address:

4.

Current Address:

5.

Current Address:

Parents'/Custodians'/Caretakers' Names (Last, First, Initial) Date of Birth/ Age Sex Race Perpetrator (Yes/No)

Mother

6.

Current Address:

Father

7.

Current Address:

Custodian/Caretaker (Relationship)

8.

Current Address:

Please specify for numbers 1 - 8 above:

Foreign language spoken: #'s Specify type:

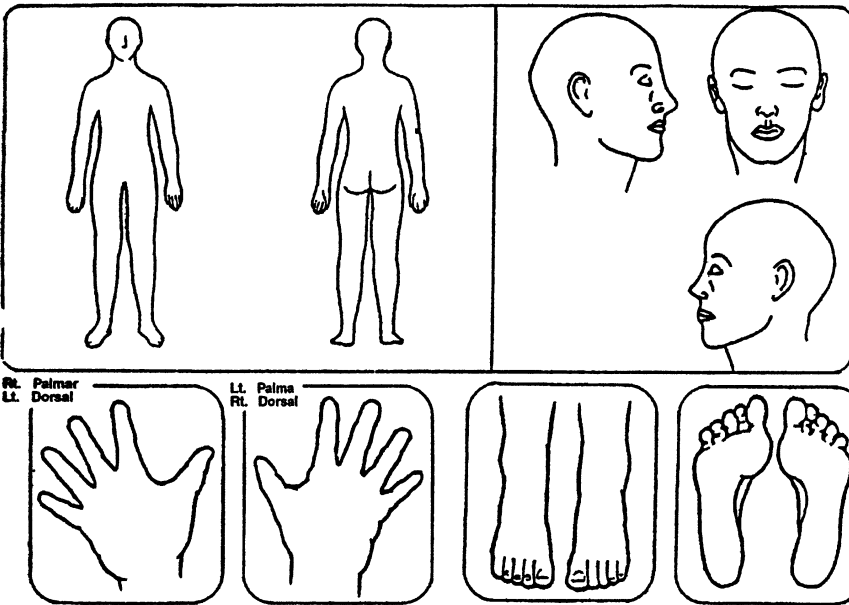
Disabilities: #'s Specify type:

DESCRIPTION

1. Describe the child's current condition/injuries and the reason you suspect abuse/neglect. Include evidence, if known, of prior abuse and/or neglect to this child or sibling. Add pages or attach further written documentation as needed.

2. If applicable, note the exact location of any injury by placing a number on the model below. Use the lines to the right of the models to describe the corresponding injury that each number represents. Check the category of injuries below.

Physical Abuse
 Sexual Abuse
 Physical Neglect



3. Actions taken "T" or pending "P"

<input type="checkbox"/> Medical Examination	<input type="checkbox"/> Notification of Police
<input type="checkbox"/> X-Rays	<input type="checkbox"/> Notification of Medical Examiner
<input type="checkbox"/> Photographs	<input type="checkbox"/> Other: _____

REPORTING SOURCE (CONFIDENTIAL)

<i>Signature</i>	<i>Title or Relationship to Child</i>	<i>Date of Report</i>
<i>Facility/Organization</i>	<i>Address</i>	<i>Telephone No.</i>

REPORT LINE USE ONLY

Date of Oral Report: _____ Report was: Accepted Rejected

Date Written Report Received: _____

Prior DFS Case Activity/Reports? Yes No If "yes", specify dates: _____