Animal Bite or Scratch Reporting Form

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Person Bitten or Scratched** | | | | | | | | | |
| **First Name** | | **Last Name** | | **DOB** | | **Employee or Student ID** | | | **Date of Injury** |
| **Local Contact Information For Injured Person** | | | | | | | | | |
| Phone Number | | Cell Number | | Address | | | | | Other Contact Information |
| City | | State | Zip Code |
| UC Affiliation, Check the box to the left of your current status | | | | | | | | | |
| UC Employee | | UC Student | | Volunteer | | No Affiliation | | | Other |
| **Injury and Animal Information**  **Describe how the injury occurred including location and body part affected, enter information about the animal in the boxes below** | | | | | | | | | |
|  | | | | | | | | | |
| **Check box to the left to indicate the animals status** | | | | | | | | | |
|  | **Research or Teaching** | |  | **Pet** | **Feral** | | **Wild** | | **Unknown** |
| If a research or Teaching animal list Animals ID and PI | | | | | ID |  | | | |
| PI |  | | | |
| Type of animal (Species) | | | Breed | | Sex Color Age | | | | |
| Is the animal vaccinated for rabies? Yes No Unknown | | | | | | | Vaccination Date and or Certificate Number if Known: | | |
| Is the Animal Licensed? Enter License Number if known: | | | | | | |
| **Did the animal appear ill or injured? Yes No** | | | | | **If Yes Describe Below:** | | | | |
|  | | | | | | | | | |
| **Where is the animal now?** | | | | | **Please Provide the owners name address and phone number** | | | | |
|  | | | | |  | | | | |
| **Did you seek medical care?** | | | Yes | No | **Date Seen** | **Where were you** Occupational Health Davis  **Seen?** Cowell Student Health | | | |
| If yes fill in the providers information below | | | | |
| Name Credentials MD RN Other | | | | | | | | Employee Health UCDMC Sutter Emergency UCDMC Emergency Other: Write in Below | |
| Address |  | | | Telephone Number | | | |
| City | | State | | Zip code | | | |
| **Enter Name of Supervisor or other Person Submitting Report that**  **can be contacted regarding Injury and Follow Up** | | | | |  | | | | |
| Phone # |  | | | Cell # | | | | Title | |
| Mailing Address | |  | | | | | | | |

Check Box Next to the Steps Below to indicate the step has been completed, different persons may be completing the steps, this

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Notify Your Supervisor or Course Instructor or Principal Investigator Date: Notify Medical Care Provider Date:

Fax Report to County Yolo: 530‐668‐5288 Date: Fax Report to Attending Veterinarians Office for Research and Teaching Animals 530‐754‐4350 Date:

Fax Report to Occupational Health Services or

Student Health Services if you did not seek Medical Care

Initial here if you received rabies counseling and provide date received:

530‐752-5277

530-752‐2312

Date: