

PLEASE PRINT



FAX COMPLETED
REPORTS TO:
(650) 685-0102

ANIMAL BITE REPORT

Reporting Facility / Person: _____ Date Reported: _____

Address: _____ Tel: _____

PERSON BITTEN	
Name: _____	DOB: ___ / ___ / ___
Street Address: _____	
City: _____	Zip: _____
Tel: Home _____	Work _____

OWNER OF ANIMAL	
Name: _____	
Street Address: _____	
City: _____	Zip: _____
Tel: Home _____	Work _____

ANIMAL	
Species: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other: _____	
Name of Animal: _____	
Age: _____	Breed: _____
Color: _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Was: <input type="checkbox"/> Leashed <input type="checkbox"/> Fenced <input type="checkbox"/> Loose	
Current Rabies Shot? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

BITE	
Address or place where bite occurred: _____	

Date Bitten: _____	
Time: _____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Where on body bitten: _____	
Skin broken? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICAL CARE OBTAINED?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, complete the following: Date of Visit _____
Physician: _____	Physician's Tel: _____ Hospital: _____

EXPLAIN CIRCUMSTANCES OF BITE INCIDENT OR ANY PREVIOUS BITE INCIDENT:	

↓ BELOW TO BE FILLED OUT BY ANIMAL SHELTER ↓	
Date Quarantined: _____	By: _____
<input type="checkbox"/> Home <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____	
Other Address: _____	
City: _____	Tel: _____
Animal No.: _____	Kennel No.: _____
License No.: _____	Expiration: _____
Date Released: _____	By: _____
Quarantine Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____	
Rabies Specimen to Health Department <input type="checkbox"/>	
Delivered by: _____	Date: _____
Rabies Vaccine Mfr: _____	Expiration: _____
Given by: _____	Lot/ Tag No.: _____
Condition of Animal Upon Release: _____	

I, the undersigned owner or person having control of the animal described in this Animal Quarantine/Bite Report, received and understand the requirements of this quarantine and will notify the PENINSULA HUMANE SOCIETY & SPCA **immediately** should the described animal become sick, injured, lost or die during the designated time period.

SIGNATURE: _____ DATE: _____

OFFICERS' COMMENTS, CONTACTS AND ACTIVITIES ON BACK OF FORM		
Return Form to: Peninsula Humane Society & SPCA 12 Airport Boulevard San Mateo, CA 94401 Tel (650) 340-8200 Fax (650) 685-0102	DATE OF BITE	OFFICIAL USE ONLY BITE REPORT NO. _____ FRA Result _____ FRA Test Date _____ PH Staff Initials _____
	DUE DATE OUT	
	DATE RELEASED	
	RELEASED BY	