

**SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF PUBLIC HEALTH – BITE COMPLAINTS**

_____ Bite/Exposure _____ - _____ Risk

Date of Bite _____ Date Received _____ By _____

OWNER OF ANIMAL	PERSON BITTEN	AGE/DOB
ADDRESS	ADDRESS	
TOWN	ZIP	TOWN ZIP
TELEPHONE #	TELEPHONE #	
HOME # _____	HOME # _____	
WORK # _____	WORK # _____	
CROSS ST.	PARENT OR GUARDIAN	
ANIMAL SPECIES _____	REPORTED BY _____	
MARKINGS _____	Medical Treatment Given by: _____	
NAME _____	<input type="checkbox"/> RIG <input type="checkbox"/> Rabies Vaccine <input type="checkbox"/> AB <input type="checkbox"/> Td <input type="checkbox"/> Wound Cleaned	
VETERINARIAN _____	_____	
DATE OF RABIES VACC. _____	_____	
EXPIRATION _____	PHONE # _____	
<u>CIRCUMSTANCES OF BITE:</u>		

<u>DESCRIPTION OF INJURY:</u>		

<u>REMARKS:</u>		

<u>FINAL DISPOSITION:</u>		
ANIMAL: _____	PATIENT: _____	
