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 # HOME # ___________________________ WORK # ___________________________	TELEPHONE # HOME # _______________________________ WORK # _______________________________
CROSS ST.	PARENT OR GUARDIAN
ANIMAL SPECIES ___________________________ MARKINGS ___________________________ NAME ___________________________ VETERINARIAN ___________________________ DATE OF RABIES VACC. ______________________ EXPIRATION ___________________________	REPORTED BY Medical Treatment Given by: _____ RIG / ______ Rabies Vaccine / ______ AB / ______ Td / ______ Wound Cleaned ____ ____ PHONE # ____

CIRCUMSTANCES OF BITE:

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DESCRIPTION OF INJURY:

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REMARKS:

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FINAL DISPOSITION:

ANIMAL: ____ **PATIENT:** ____

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