



Vector Control – Animal Bite Reporting Form

ANIMAL OWNER INFORMATION:

Name: _____ Phone: _____ MR# _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____ DOB: _____

ANIMAL INFORMATION:

Animal Species: Dog Cat Other: _____

Sex: _____ Breed: _____ Color: _____

License: Yes _____ - _____ No Unknown

Rabies Vaccination: Yes No Unknown

VICTIM INFORMATION:

Name: _____ Phone: _____ MR# _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____ DOB: _____

Part of Body Injured: _____ Date of Injury: _____

Where Treated: _____

Location of Incident: _____

Primary Care Physician: _____

REPORT SUBMITTED BY:

Name: _____ Title: _____ Date: _____

WITHIN 24 HOURS

Please fax this form to the Health Department:
Communicable Disease Management (231) 724-1325 and Vector Control (231) 724-6009