



VETERINARY PUBLIC HEALTH-RABIES CONTROL PROGRAM
 TEL: (213)-989-7060 or (877) 747-2243 Fax: (213)-481-2375
publichealth.lacounty.gov/vet



ANIMAL CONTROL AGENCIES

| PERSON BITTEN | | | | | |
|--|--|---|---|--|----------------------------|
| Victim name (last and first) | | Date of Birth | | Address (number, street, city and zip) | |
| Victim phone number | | Reported by: | | | Reporter phone number |
| Date bitten | Time bitten | Address where bitten (if no address make sure to put city and zip code) | | | Body location bitten |
| How bite occurred (explain) | | | | | |
| | | | | | |
| Date Treated | Hospitalized <input type="checkbox"/> YES <input type="checkbox"/> NO | | Treated by | | Phone number |
| Type of treatment | | | | | |
| ANIMAL | | | | | |
| Owner Name (last and first) | | | Address (number, street city and zip) | | |
| Phone Number | | Type of animal <input type="checkbox"/> Dog Breed _____ <input type="checkbox"/> Cat Breed _____ <input type="checkbox"/> Other _____ | | Description of animal (sex, color) | |
| Animal Impounded <input type="checkbox"/> YES <input type="checkbox"/> NO | | Animal Shelter | | | Impound # |
| Was animal taken to a clinic for treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | | If yes, provide clinic address in this space. | | | |
| Current Rabies Vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Date Vaccinated | | Animal sterilized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not verified | |
| Animal licensed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | License number | | Expiration date | City or county licensed in |
| Animal Died? <input type="checkbox"/> Yes <input type="checkbox"/> No | Euthanized? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ | | Specimen prepared for rabies testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable | | |
| Remarks: | | | | | |
| Agency taking report: | | | | | |
| Date | | Time | | Faxed: <input type="checkbox"/> yes <input type="checkbox"/> No | Initials |