NAME OF DOCTOR OR CLINIC:_____

ADDRESS:_____ CITY:_____

ZIP:_____ **PHONE:**_____

ANIMAL BITE REPORTING FORM

DATE OF BITE:_____ DATE OF SERVICE:_____

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE:_____

OWNER OF ANIMAL:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE:_____

LOCATION WHERE INJURY OCCURRED:_____

INJURY SITE:_____

TYPE OF ANIMAL:_____

RABIES SHOTS CURRENT:_____

TREATMENT RECEIVED:_____

TREATING PHYSICIAN:_____

HEALTH DEPARTMENT PHONE NUMBER: 270-821-5242 FAX NUMBER: 270-825-0138

FAX COMPLETED FORM TO THE HEALTH DEPARTMENT WITHIN 12 HOURS OF OFFICE VISIT