

**WRITTEN CONFIRMATION OF SUSPECTED CHILD ABUSE/NEGLECT REPORT:  
MEDICAL PROFESSIONALS**

**NOTE:** Hospitals and medical personnel engaged in examination, care, and treatment of persons are required by the Abused and Neglected Child Reporting Act to report to the Illinois Department of Children and Family Services all suspected cases of child abuse or neglect. The Act provides that anyone participating in this report shall be presumed to be acting in good faith and in so doing shall be immune from liability, civil or criminal, that otherwise might be incurred or imposed.

Child's Name \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (Zip) (County)

Parent's/Custodian's Name \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (Zip) (County)

Where first seen \_\_\_\_\_ Date \_\_\_\_\_

Brought In by \_\_\_\_\_ Relationship \_\_\_\_\_

Nature of child's condition:

Evidence of previous suspected abuse(s)/neglect:

Reporter's immediate plan for child including whereabouts:

Remarks:

Person presumed to have abused/neglected child: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Sibling <input type="checkbox"/> Other _____																			
PERSON MAKING REPORT  Name (Please Print) _____  Medical Facility _____  Address _____  Date _____	PERSON MAKING REPORT (Check Appropriate Box)  <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Attending Physician</td> <td><input type="checkbox"/> Podiatrist</td> </tr> <tr> <td><input type="checkbox"/> Surgeon</td> <td><input type="checkbox"/> Chiropractor</td> </tr> <tr> <td><input type="checkbox"/> Hospital Administrator</td> <td><input type="checkbox"/> Christian Science Practitioner</td> </tr> <tr> <td><input type="checkbox"/> Medical Examiner</td> <td><input type="checkbox"/> Social Worker</td> </tr> <tr> <td><input type="checkbox"/> Coroner</td> <td><input type="checkbox"/> Social Services Administrator</td> </tr> <tr> <td><input type="checkbox"/> Registered Nurse</td> <td><input type="checkbox"/> Registered Psychologist</td> </tr> <tr> <td><input type="checkbox"/> Licensed Practical Nurse</td> <td><input type="checkbox"/> Psychiatrist</td> </tr> <tr> <td><input type="checkbox"/> Dentist</td> <td><input type="checkbox"/> Advanced Practice Nurse</td> </tr> <tr> <td><input type="checkbox"/> Osteopath</td> <td><input type="checkbox"/> Other _____</td> </tr> </table> Signature _____	<input type="checkbox"/> Attending Physician	<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Surgeon	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Hospital Administrator	<input type="checkbox"/> Christian Science Practitioner	<input type="checkbox"/> Medical Examiner	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Coroner	<input type="checkbox"/> Social Services Administrator	<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Registered Psychologist	<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Dentist	<input type="checkbox"/> Advanced Practice Nurse	<input type="checkbox"/> Osteopath	<input type="checkbox"/> Other _____
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## INSTRUCTIONS

The Abused and Neglected Child Reporting Act states that any hospital, clinic or private facility to which a child comes or is brought suffering from injury, physical abuse or neglect apparently inflicted upon him, other than by accidental means, shall promptly report or cause reports to be made in accordance with provisions of the Act.

The report should be made immediately by telephone to the IDCFS Child Abuse Hotline (800-252-2873) and confirmed in writing via the U.S. Mail, postage prepaid, within 48 hours of the initial report.

This form is provided for the convenience of the hospital, clinic or private facility in making the written report. A form must be completed for each child.

Enter the full name of the child, sex, age and address. Give the first and last names of the parents or persons having custody of the child. If the address is the same as that of the child, indicate by "same."

Where first seen: Give the date the child was first seen; indicate if in-patient, clinic, emergency room, doctor's office or another specified place within the hospital, and by whom the child was brought in.

Nature of the child's condition and evidence of previous suspected abuse(s)/neglect: Self-explanatory.

Reporter's plan for child: Indicate whether child is to remain in the hospital and for how long, or be released and, if so, to whom. State any other pertinent information as to the plan.

Remarks: If a report was also made to a local law enforcement agency, state to which agency report was made. Include any additional information deemed appropriate to the case.

Give the name of the Attending Physician, name and address of the hospital, if report is from the hospital.

Signature: The report is to be signed by the person making the report.

## MAILING INSTRUCTIONS

Mail the original to the nearest office of the Illinois Department of Children and Family Services, Attention: Child Protective Services

DCFS is an equal opportunity employer, and prohibits unlawful discrimination in all of its programs and/or services.
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