

**Kansas Department of Health and Environment**

Bureau of Child Care and Health Facilities  
1000 SW Jackson, Suite 200



Topeka, KS 66612-1274  
Phone 785-296-1270 Fax 785-296-7025

**REPORT OF SUSPECTED ABUSE/NEGLECT, DEATH, SERIOUS INJURY OF STAFF  
OR RESIDENT IN A SECURE RESIDENTIAL TREATMENT FACILITY TO KDHE**

\*CHILD'S NAME \_\_\_\_\_ \*CHILD'S DATE OF BIRTH \_\_\_\_\_

\*DATE OF INJURY/INCIDENT \_\_\_\_\_ TIME \_\_\_\_\_ AM \_\_\_\_\_ PM

\*DESCRIPTION OF INJURY/INCIDENT \_\_\_\_\_

\*ACTION TAKEN AT FACILITY AFTER INJURY/INCIDENT (FIRST AID, SAFETY PLAN) \_\_\_\_\_

DOCTOR CONSULTED \_\_\_\_\_ ADDRESS \_\_\_\_\_

DOCTOR'S DIAGNOSIS \_\_\_\_\_

STAFF IN CHARGE WHEN INJURY/INCIDENT OCCURRED \_\_\_\_\_ SHIFT \_\_\_\_\_

WITNESSES TO INJURY/INCIDENT:	NAME	Resident or Staff	Usual shift (if staff)
_____	_____	R S	_____
_____	_____	R S	_____
_____	_____	R S	_____

DESCRIPTION OF ACTIVITY, LOCATION IN FACILITY AND CIRCUMSTANCES IMMEDIATELY BEFORE AND AT TIME OF INJURY/INCIDENT (indicate any victim names and DOB): \_\_\_\_\_

WHAT CORRECTIVE MEASURES COULD BE TAKEN TO ELIMINATE SUCH INJURIES OR INCIDENTS IN THE FUTURE? \_\_\_\_\_

REPORT PREPARED BY \_\_\_\_\_ DATE \_\_\_\_\_  
Name/Signature Title

\*NAME OF FACILITY \_\_\_\_\_ LIC. NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX NUMBER \_\_\_\_\_

REPORT TO	✓	DATE	TIME	REPORT TO	✓	DATE	TIME
SRS				Parent			
Police				Placing Agency			
KDHE District Office				County Health Dept.			

IN ACCORDANCE WITH K.A.R. 28-4-341, IF TELEPHONING REPORT TO KDHE, BE PREPARED TO GIVE DATA MARKED WITH AN ASTERISK AND FOLLOW UP WITHIN 5 DAYS WITH THE COMPLETED FORM.

**Directions for submission related to K.A.R. 28-4-341(8):** Fax completed form within 24 hours (excluding weekends and holidays) to KDHE District Office and your county health department. Notify SRS of any suspected abuse or neglect of a child.