

State of California
California Emergency Management Agency

MANDATED SUSPICIOUS INJURY REPORT

CAL EMA 2-920



For more information or assistance in completing the CAL EMA 2-920, please contact
California Clinical Forensic Medical Training Center at:
(916) 930-3080 or www.ccfmtc.org

This form is also available on the following website:
www.calema.ca.gov

SUSPICIOUS INJURY REPORT

CalEMA 2-920 (12/03)



STATE OF CALIFORNIA

INFORMATION DISCLOSURE

This form is for law enforcement use only and is confidential in accordance with Section 11163.2 of the Penal Code. This form shall not be disclosed except by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by this report. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts. The person making this report shall not be required to disclose his/her identity to their employer (PC 11160).

Part A: PATIENT WITH SUSPICIOUS INJURY

1. PATIENT'S NAME (Last, First, Middle)	2. BIRTH DATE	3. GENDER <input type="checkbox"/> M <input type="checkbox"/> F	4. SAFE PHONE NUMBER ()
5. PATIENT'S RESIDING ADDRESS (Number and Street / Apt – NO P.O. Box)		City	State Zip
6. PATIENT SPEAKS ENGLISH <input type="checkbox"/> Y <input type="checkbox"/> N – Identify language spoken: _____		7. DATE AND TIME OF INJURY Date: _____ Time: <input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/> Unknown	
8. LOCATION / ADDRESS WHERE INJURY OCCURRED, IF AVAILABLE – Check here if unknown: <input type="checkbox"/>			
9. PATIENT'S COMMENTS ABOUT THE INCIDENT – Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident.			<input type="checkbox"/> ADDITIONAL PAGES ATTACHED

10. NAME OF SUSPECT – If identified by the patient	11. RELATIONSHIP TO PATIENT, IF ANY
12. SUSPICIOUS INJURY DESCRIPTION – Include a brief description of physical findings and the final diagnosis.	
<input type="checkbox"/> ADDITIONAL PAGES ATTACHED	

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. LAW ENFORCEMENT AGENCY NOTIFIED BY PHONE (Mandated by PC 11160)	14. DATE AND TIME REPORTED Date: _____ Time: <input type="checkbox"/> am <input type="checkbox"/> pm
15. NAME OF PERSON RECEIVING PHONE REPORT (First and Last)	16. JOB TITLE
17. PHONE NUMBER ()	
18. LAW ENFORCEMENT AGENCY RECEIVING WRITTEN REPORT (Mandated by PC 11160)	19. AGENCY INCIDENT NUMBER

Part C: PERSON FILING REPORT

20. EMPLOYER'S NAME	21. PHONE NUMBER ()
22. EMPLOYER'S ADDRESS (Number and Street)	
City	
State Zip	
23. NAME OF HEALTH PRACTITIONER (First and Last)	24. JOB TITLE
25. HEALTH PRACTITIONER'S SIGNATURE:	
26. DATE SIGNED:	