

State of California  
Office of Emergency Services  
([www.oes.ca.gov](http://www.oes.ca.gov))

# MANDATED SUSPICIOUS INJURY REPORT

## CAL OES 2-920



For copies of this form or assistance in completing the Cal OES 2-920, please contact the  
**California Clinical Forensic Medical Training Center:**  
(916) 930-3080 or  
Contact Us @ [www.ccfmtc.org](http://www.ccfmtc.org)

# SUSPICIOUS INJURY REPORT

STATE OF CALIFORNIA

California Office of Emergency Services

## Cal OES 2-920

Confidential Document

Penal Code Section 11160 requires that if any health practitioner, within their scope of their employment, provides medical services for a wound or physical injury inflicted as a result of assaultive or abusive conduct, or by means of a firearm, shall make a telephone report immediately or as soon as possible. They shall also prepare and submit a written report within 2 working days of receiving the information to a local law enforcement agency. This is the official form (Cal OES 2-920) for submitting the written report.

This form is used by law enforcement only and is confidential in accordance with Section 11163.2 of the Penal Code. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts.

### Part A: PATIENT WITH SUSPICIOUS INJURY

1. Name of Patient (Last, First, Middle)	2. Birth Date	3. Gender <input type="checkbox"/> M <input type="checkbox"/> F	4. SAFE Telephone Number
5. Patient Address (Number and Street / Apt – No P.O. Box)		City	State Zip
6. Patient Speaks English <input type="checkbox"/> Yes <input type="checkbox"/> No If No, 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 description of 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. <input type="checkbox"/> No Relationship		
12. Suspicious Injury Description. Include a brief description of physical findings, lab tests completed or pending, and other pertinent information. <input type="checkbox"/> Additional Pages			

### 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: am pm		
15. Name of Person Receiving Phone Report (First and Last)	16. 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. Name of Health Practitioner (First and Last)	Title	Telephone	
21. Employer's Name	Phone Number		
22. Employer's Address (Number and Street)	City	State	Zip
23. HEALTH PRACTITIONER'S SIGNATURE:			26. Date Signed: