



Mandated Reporting form for Indian Child Welfare
 please send to referrals@chehalistrike.org and/or amendoza@chehalistrike.org
 (Form SS06)

Type of Harm	Check
Physical Abuse	
Sexual Abuse	
Psychological/emotional abuse	
Threat of physical abuse	
Threat of physical neglect	
Threat of psychological harm	
Unknown/Other	

<p>Date of Report:</p> <hr/>

Evidence of Harm	Check
Subdural/multiple skin bruising/internal bleeding (Any obvious bruising)	
Injury causing substantial bleeding	
Injury causing substantial bleeding	
Malnutrition	
Failure to thrive	
Burns	
Any fracture	
Long sleeve clothing in hot weather (may be hiding bruises)	
Extreme pain	
Extreme mental illness	
Not engaging with people when talked to	
Death	
Physical or medical evidence of sexual abuse	
Injury to the psychological capacity/impairment in child's functioning	
Intentional Drugging	
Failure to provide adequate care or supervision to children	
Unknown/Other	
No evidence visible	

Household Information- (if unknown, please leave blank)

Victim Name: _____ Age: _____

Phone Number: _____

Address (if known): _____



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Alleged Perpetrator:

- | | | | |
|----------------------------------|---------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Step-Mother | <input type="checkbox"/> Maternal Grandmother | <input type="checkbox"/> Other |
| <input type="checkbox"/> Father | <input type="checkbox"/> Step- Father | <input type="checkbox"/> Maternal Grandfather | |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Step-Brother | <input type="checkbox"/> Cousin | |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Step- Sister | <input type="checkbox"/> Foster Sibling | |

Name: _____ Age: _____

Relationship to victim: _____

Address (if known):

Mandated reporter Information: *(Information will be kept confidential unless a court filing occurs. In this case, agency/Name may need to be shared):*

- | | |
|--|--|
| <input type="checkbox"/> Behavioral Health Staff | <input type="checkbox"/> Chehalis Tribal Head Start |
| <input type="checkbox"/> Wellness Center Staff (including dental) | <input type="checkbox"/> Oakville School (Elementary/middle/ High) |
| <input type="checkbox"/> Youth/ Community Center (Including education) | <input type="checkbox"/> Grand Mound Elementary |
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Rochester Primary |
| <input type="checkbox"/> Chehalis Tribal Housing Authority | <input type="checkbox"/> Rochester Middle School |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Rochester High School |

Reporter's name: _____

Address of information received:

Telephone: (____) - _____ - _____ Ext: _____ Personal Cell Desk phone Work Cell

Do you know the address of where the harm occurred? Yes No

If yes, please describe:

