



CITY OF SAN ANTONIO ANIMAL CARE SERVICES

4710 State Highway 151 San Antonio, Texas 78227
Fax: (210) 207-6673



Activity Number:	Bite Case Number:
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**Please place all information on the front of this document.
Do not write on the back of this paper or on your own paper.**

APPLICANT INFORMATION

Name:	DOB:	Driver's License No:
Street Address:	City/State:	Zip:
Phone:	Email:	
Did anyone other than you witness the incident? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, please fill out "Witness Information" section below.</i>		

WITNESS INFORMATION (If Available)

Name:	Phone:
Street Address:	City/State: Zip:
Additional witnesses may be listed in the last section.	

INCIDENT INFORMATION

Where did the incident happen?		
When did the incident happen?	<i>Date:</i>	<i>Time:</i>
Did the attack occur on the dog owner's property? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was the dog owner present? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no, where did the attack happen? (Address or Street block)		
Sidewalk <input type="checkbox"/> Street <input type="checkbox"/> Driveway <input type="checkbox"/> Front yard <input type="checkbox"/> Back yard <input type="checkbox"/> Easement <input type="checkbox"/> Intersection <input type="checkbox"/> Inside Home <input type="checkbox"/>		
Did the attack occur in a fenced yard or enclosed area? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Did you believe you or another person would be attacked and that the dog would injure you or them? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, briefly describe how or why?		
Do you believe that you (or bite victim, if not you) did anything to cause the dog to attack? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please describe what you were doing at the time of the attack:		

MEDICAL INFORMATION – HUMAN VICTIM

Did you receive any injuries as a result of this incident? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>If yes, complete this section. If no, skip to next section.</i>	
Did you receive medical treatment at a clinic or hospital? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Hospital or Clinic where you were treated:	Can you provide documentation or pictures?
Name:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Address:	Are you willing to provide Animal Care Services with Medical Records? Yes <input type="checkbox"/> No <input type="checkbox"/>
Phone Number:	
If yes, please describe the location and severity of your injury(ies):	
Name of Attending Physician:	Phone:
Address:	



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MEDICAL INFORMATION – ANIMAL VICTIM

Did your animal receive any injuries? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, complete this section. If no, skip to the next section.</i>		Nature of Injuries:
Did you animal require any medical treatment as a result of injuries sustained in the incident? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of Attending Veterinarian:		Phone:
Address:		
Do you have photos of the injuries? Yes <input type="checkbox"/> No <input type="checkbox"/>		Who took the photos?
Can you provide Animal Care Services with medical documentation of your pet's injuries? Yes <input type="checkbox"/> No <input type="checkbox"/>		

ATTACKING DOG INFORMATION

Dog Name <i>(If known)</i> :		Breed or Type:			
Color:	Is the dog a: Puppy <input type="checkbox"/> Young Adult <input type="checkbox"/> Adult <input type="checkbox"/> Senior <input type="checkbox"/> Unknown <input type="checkbox"/>				
Was the dog wearing a collar or harness? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, what color?</i>					
Have you seen the dog before? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, when and where?</i>					
Describe the animal's behavior:					
Have you observed aggressive behavior from the dog prior to the attack/incident?					

ATTACKING DOG – OWNER INFORMATION

Is the dog owned? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		
Owner's Name <i>(If known)</i> :		
Owner's Address		
Is the owner someone that you know personally? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, how?</i>		
How do you know dog(s) are owned by the person/address listed above?		
Have you communicated with the owner in writing in regards to their dog attack? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, briefly describe the conversation. Please do not include any conversations regarding <u>civil litigation</u> .		

NARRATIVE PORTION – PLEASE DESCRIBE THE ATTACK



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ADDITIONAL WITNESSES:

NAME	ADDRESS	PHONE NUMBER

ADDITIONAL DOGS INVOLVED OR POSSIBLY INVOLVED

NAME	BREED OR TYPE	COLOR	OWNER (If Known)

ADDITIONAL INFORMATION RELEVANT TO THE CASE

SIGNATURE: _____
(Must be Signed in the Presence of a Texas Notary Public)

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

STATE OF TEXAS
COUNTY OF BEXAR

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS _____ DAY OF _____, 20 ____.

Notary Signature: _____

My Commission Expires: _____

OFFICE USE ONLY:

RECEIVED BY	DATE RECEIVED	REVIEWED BY	DATE REVIEWED
OUTCOME: APPROVED <input type="checkbox"/> REJECTED <input type="checkbox"/>		REASON IF REJECTED:	
Follow-Up Type: Dangerous <input type="checkbox"/> Aggressive <input type="checkbox"/> SBI <input type="checkbox"/> ABD <input type="checkbox"/> ABDD <input type="checkbox"/> ADW/ABI <input type="checkbox"/> Other: _____			