

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
REPORT OF DEATH OF CHILD IN CHILD CARE

SUBMITTED BY:	
<input type="checkbox"/> Regional Office/ _____	<input type="checkbox"/> Borough Office (NYCDOH/MH)
PROGRAM NAME (Name of Provider/Director):	
CCFS #:	PHONE #:
ADDRESS (Street, city zip code):	
TYPE OF CARE:	DATE OF ORIGINAL LICENSE OR REGISTRATION: / /
CURRENT COMPLIANCE STATUS OF PROGRAM (CHECK ALL THAT APPLY):	
<input type="checkbox"/> IN COMPLIANCE	<input type="checkbox"/> RENEWAL OVERDUE
<input type="checkbox"/> ILLEGAL PROVIDER	<input type="checkbox"/> OPEN COMPLAINTS
	<input type="checkbox"/> SUBSTANTIATED COMPLAINTS
	<input type="checkbox"/> OTHER _____
NAME OF DECEASED CHILD:	
CHILD'S DATE OF BIRTH: / /	CHILD'S GENDER : <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
NAMES OF PARENT/GUARDIAN:	
ADDRESS OF PARENT/GUARDIAN (Street, city, zip code):	
SOURCE OF REPORT OF DEATH:	
DATE OF DEATH: / /	TIME OF DEATH OR APPROXIMATION: : <input type="checkbox"/> AM <input type="checkbox"/> PM
WERE THE PARAMEDICS OR AN AMBULANCE CALLED?: <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, BY WHOM? (Name and position):
WERE THE POLICE CALLED OR INVOLVED?: <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GIVE NAME/UNIT:
WAS CHILD TAKEN TO HOSPITAL?: <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS A CPS REPORT MADE?: <input type="checkbox"/> YES <input type="checkbox"/> NO
CASE ID# (If Known):	IF YES, GIVE REPORT DATE: / /
SOURCE OF REPORT, IF KNOWN:	
NAME OF CPS INVESTIGATOR:	
WAS REGULATORY COMPLAINT ENTERED IN CCFS?: <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GIVE DATE OF COMPLAINT: / /
COMPLAINT #:	

PRELIMINARY INCIDENT EXPLANATION: Give a brief description of the events leading to the child's death, including: time of arrival, eating and sleeping arrangements or habits, location of child when illness or death occurred, what the child was doing, description of supervision (number of children, number of adults, etc.)at time of the incident or leading up to it and other factors or information helpful in understanding what happened.

ARE THERE ANY ALLEGATIONS IN ADDITION TO FATALITY ALLEGATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		INITIAL DCCS INSPECTION DATE: / /
DCCS INSPECTOR:		
ANY VIOLATION(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDETERMINED		
WHICH LAW ENFORCEMENT AGENCIES ARE INVESTIGATING THE CHILD'S DEATH?		
NAME OF POLICE DEPARTMENT:		PHONE NUMBER: ()
NAME OF TITLE OF INVESTIGATOR:		POLICE REPORT #:
NAME OF HOSPITAL:		HOSPITALS PHONE #:
NAME OF DOCTOR:		DOCTOR'S PHONE #:

TO BE COMPLETED UPON RECEIPT OF MEDICAL EXAMINER'S REPORT

MEDICAL EXAMINER'S REPORT #:	NAME OF MEDICAL EXAMINER:
CAUSE OF DEATH AS DETERMINED BY MEDICAL EXAMINER:	
HAS THE DISTRICT ATTORNEY'S OFFICE BEEN NOTIFIED OF THE RESULTS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, WHAT ARE THE GROUNDS FOR PURSUING LEGAL ACTION?	