

Fire / Explosion Incident Report Form

Complete this form and submit to appropriate State Licensing Agency within seven (7) calendar days of incident.

FACILITY INFORMATION				
Facility Name:			NPI#:	
Street Address:				
City:		County:		Zip:
Phone: ())				Fax: ())
Email Address:				
Type of Facility:				
<input type="checkbox"/> SNF/NF	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Hospital	<input type="checkbox"/> ICF/DD	<input type="checkbox"/> Ambulatory Surgical
<input type="checkbox"/> Hospice (In-Patient)		<input type="checkbox"/> ESRD	<input type="checkbox"/> Lab	<input type="checkbox"/> Other

FIRE / EXPLOSION REPORTING INFORMATION				
Name of Individual Reporting Fire/Explosion:				
Title of Person Reporting Fire/Explosion:				
<input type="checkbox"/> Facility Owner	<input type="checkbox"/> Administrator	<input type="checkbox"/> Staff Member	<input type="checkbox"/> Maintenance	
<input type="checkbox"/> Visitor	<input type="checkbox"/> Patient	<input type="checkbox"/> Other		
Device Used to Report Fire/Explosion:				
<input type="checkbox"/> Pull Alarm	<input type="checkbox"/> Fire Detector	<input type="checkbox"/> Telephone		

DESCRIPTION OF INCIDENT				
Date of Fire/Explosion:			Time Occurred:	
			[] am [] pm	
Location of Fire/Explosion within Facility:				
<input type="checkbox"/> Kitchen	<input type="checkbox"/> Storage Room	<input type="checkbox"/> Mechanical Room	<input type="checkbox"/> Electrical Room	<input type="checkbox"/> Common Area
<input type="checkbox"/> Patient Room (Room #)			Other:	
Was Evacuation of Patients Necessary?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, How many were evacuated?:				

DESCRIPTION OF INCIDENT continued			
Was Smoke Compartmentalization Utilized for Evacuation?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, please describe:			
Were there any injuries?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, How Many:		Describe the types of injuries:	
Were there any deaths?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES, How Many:			
Type of Fire Fighting Equipment Used to Extinguish the Fire:			
<input type="checkbox"/> Water	<input type="checkbox"/> Fire Extinguisher	<input type="checkbox"/> CO2	<input type="checkbox"/> Dry Chemical
<input type="checkbox"/> Hose	<input type="checkbox"/> None	<input type="checkbox"/> Other:	
Known or probable cause of the fire:			
Describe the local Fire Department's Participation: (use additional paper if needed)			

DAMAGE ASSESSMENT	
Extent of Flame, Smoke, Water or Other Damage:	
Is the facility, or sections of the facility unusable by patients or staff? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If YES, estimate time needed for repairs:	
Estimated dollar amount of damage: \$	
What steps have been taken by the facility to prevent reoccurrence? (use additional paper if needed)	

Date: _____ Signature: _____

Title: _____ Printed Name: _____