FACILITY FIRE INCIDENT REPORT

Print Form

Facility Name

Address City Zip Code

Contact Person Phone Number

Date of Fire Time: Day of week

Room/location of fire origin:

Area fire covered:

Area smoke covered:

Initial material ignited (*if known*):

Probable source of Ignition (if known):

Probably cause of fire (if known):

How was the fire discovered? ☐ Detector ☐ Sprinkler

☐ Patient/Resident Name:

☐ Staff Name:

☐ Other Specify

Was the fire alarm activated? ◯ Yes ◯ No

If "Yes", how: ☐ Detector ☐ Manually ☐ Sprinkler ☐ Staff ☐ Patient/Resident

☐ Other Specify

Was the fire department notified? ◯ Yes ◯ No

If "Yes", how: ☐ Phone ☐ Direct Line/Alarm

If "No", why not

Were patients/residents evacuated? ◯ Yes ◯ No

If "Yes": ☐ From room of origin ☐ To another facility ☐ Through fire or smoke doors ☐ To shelter or other

How long ☐ Outside the building- Provide site map indicating location taken to.

How was the fire extinguished?

Extent of injury (injuries) if any:

Monetary loss: Building: **$** Contents **$**

Actions take to prevent recurence:

(Continued on next page)

Current Date

Problems encountered

Successes

Person completing report:

Position

Phone Number