South Dakota Department of Health
Health Systems Development and Regulation
Office of Health Care Facilities Licensure & Certification

Health Care Facility Fire Incident Report

NAME OF FACILITY_____ **CITY**_____

DATE OF FIRE_____**TIME OF FIRE**_____ ☐ **AM** ☐ **PM**

FIRE LOCATION IN BUILDING_____

TIME FIRE DEPARTMENT CALLED _____**TIME OF ARRIVAL**_____

CAUSE OF FIRE_____

EVACUATION OF PATIENTS ☐ **YES** ☐ **NO** **IF YES, HOW MANY**_____

NUMBER OF PERSONS INJURED _____ _____ _____ _____
NONE PATIENTS STAFF OTHER

NUMBER OF DEATHS _____ _____ _____ _____
NONE PATIENTS STAFF OTHER

EXTENT OF DAMAGE_____

DESCRIBE FIRE INCIDENT AND STAFF RESPONSE (USE BACK IF NECESSARY)

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WHAT CAN BE DONE TO PREVENT RECURRENCE_____

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SIGNATURES REQUIRED OF THE FOLLOWING INDIVIDUALS:

PERSON PREPARING REPORT_____**DATE**_____

ADMINISTRATOR_____**DATE**_____

DEPARTMENT OF HEALTH_____**DATE**_____
(ENGINEERING SECTION)

FIRE REPORT

PLEASE RETURN TO:

South Dakota Department of Health
Office of Health Care Facilities
Licensure and Certification
615 E 4th Street
Pierre SD 57501-1700
Phone 605-773-3356
Fax 605-773-6667