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

<table>
<thead>
<tr>
<th></th>
<th>NONE</th>
<th>PATIENTS</th>
<th>STAFF</th>
<th>OTHER</th>
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NUMBER OF DEATHS

<table>
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<tr>
<th></th>
<th>NONE</th>
<th>PATIENTS</th>
<th>STAFF</th>
<th>OTHER</th>
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EXTENT OF DAMAGE ____________________________________________________________

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

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

WHAT CAN BE DONE TO PREVENT RECURRENCE ______________________________________

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

SIGNATURES REQUIRED OF THE FOLLOWING INDIVIDUALS:

PERSON PREPARING REPORT ______________________ DATE ______________________

ADMINISTRATOR ______________________ DATE ______________________

DEPARTMENT OF HEALTH (ENGINEERING SECTION) ______________________ DATE ______________________

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