

Date Rec'd: _____

Time Rec'd: _____

Fire Fatality Report Form

Date of Incident:		Alarm Time (24 Hr):		Municipality:	
Incident Address:				Zip:	
Fire Department Name:				FDID:	
				NFIRS Participant:	
				(Check One)	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				Yes	
				No	

Name:	Age:	Gender:	Affiliation: (Check One)	<input type="checkbox"/>	Civilian
				<input type="checkbox"/>	Firefighter
				<input type="checkbox"/>	Other Emergency Personnel
Name:	Age:	Gender:	Affiliation: (Check One)	<input type="checkbox"/>	Civilian
				<input type="checkbox"/>	Firefighter
				<input type="checkbox"/>	Other Emergency Personnel
Name:	Age:	Gender:	Affiliation: (Check One)	<input type="checkbox"/>	Civilian
				<input type="checkbox"/>	Firefighter
				<input type="checkbox"/>	Other Emergency Personnel
Name:	Age:	Gender:	Affiliation: (Check One)	<input type="checkbox"/>	Civilian
				<input type="checkbox"/>	Firefighter
				<input type="checkbox"/>	Other Emergency Personnel
Name:	Age:	Gender:	Affiliation: (Check One)	<input type="checkbox"/>	Civilian
				<input type="checkbox"/>	Firefighter
				<input type="checkbox"/>	Other Emergency Personnel
Name:	Age:	Gender:	Affiliation: (Check One)	<input type="checkbox"/>	Civilian
				<input type="checkbox"/>	Firefighter
				<input type="checkbox"/>	Other Emergency Personnel

Cause of Fire:		Type of Occupancy:	
		Room of Origin:	
Detector Present:	<input type="checkbox"/>	Detector Operate:	<input type="checkbox"/>
(Check One)	Yes	(Check One)	Yes
	No		No

Reporting Agency:	Name: (Person Completing Form)	Phone:
Remarks:		