



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 DIVISION OF REGULATION AND LICENSURE  
 SECTION FOR LONG-TERM CARE REGULATION  
**FIRE REPORT**

FOR SLCR USE ONLY	
DATE REGION SENT TO CENTRAL OFFICE	FACILITY ID NUMBER
FIRE LOCATION	FIRE CAUSE

FACILITY NAME		REGION
FACILITY ADDRESS		COUNTY
OWNER	ADMINISTRATOR	
DATE OF FIRE	TIME FIRE WAS DISCOVERED	WHO DISCOVERED THE FIRE?
TIME FIRE DEPARTMENT ARRIVED	LOCATION IN THE FACILITY AND CAUSE OF FIRE	
AMOUNT OF DAMAGE CAUSED BY FIRE	CENSUS AT TIME OF FIRE (NUMBER)	
WAS FIRE ALARM ACTIVATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	TIME ALARM WAS ACTIVATED	DATE/TIME FIRE ALARM WAS PUT BACK IN SERVICE IF ACTIVATED
WAS SPRINKLER SYSTEM ACTIVATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE/TIME SPRINKLER SYSTEM WAS PUT BACK IN SERVICE IF ACTIVATED	
NUMBER OF STAFF ON DUTY	IF EVACUATION WAS REQUIRED, NUMBER OF RESIDENTS REQUIRING ASSISTANCE	
NUMBER OF INJURIES OR DEATHS TO RESIDENTS OR EMPLOYEES AS RESULT OF FIRE	NUMBER RESULTING FROM SMOKE INHALATION	NUMBER RESULTING FROM BURNS
IS ARSON SUSPECTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME AND CONTACT INFORMATION OF INVESTIGATING FIRE/POLICE OFFICIAL	
CIRCUMSTANCES THAT MAY HAVE PREVENTED THE FIRE, IF ANY.		
REMARKS (ATTACH A BRIEF NARRATIVE OF THE EVENTS - IF THE FIRE CAN BE ATTRIBUTED TO A PARTICULAR PERSON(S), INCLUDE THEIR NAME AND IDENTIFYING DATA.)		
FACILITY ADMINISTRATOR/MANAGER SIGNATURE	TITLE	DATE
PLEASE PRINT NAME OF PERSON SIGNING ABOVE		
ADDRESS		
CITY, STATE, ZIP CODE		
RETURN TO: <b>MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES</b> <b>DIVISION OF REGULATION AND LICENSURE</b> <b>SECTION FOR LONG-TERM CARE REGULATION REGION _____</b>		
FIRE DEPARTMENT REPORT ATTACHED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, PLEASE EXPLAIN	