

**\*\*\* Fire Department Use Only \*\*\***

**NFIRS 5.0 FIELD CASUALTY FORM**

FTA Consultants 4/04

<b>FDID</b>	<b>INCIDENT NO.</b>	<b>EXP</b>	<b>Month</b>	<b>Day</b>	<b>Year</b>	<b>Day of Week</b>	<b>Alarm Time</b>	<b>Casualty #</b>			
<b>Alarm Location</b>			<small>[Number/Street Name / Apartment #]</small>					<b>County</b>	<b>TWP.</b>		
<b>Injured Person [Name / Gender / Affiliation Information]</b>							<b>DOB</b>	<b>Age</b>			
<small>First Name</small> _____ <small>MI</small> _____ <small>Last Name</small> _____ <small>Suffix</small> _____							____/____/____	____	____		
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> <b>FIRE DEPT</b> <input type="checkbox"/> Paid <input type="checkbox"/> Volunteer <input type="checkbox"/> EMS, NOT FD <input type="checkbox"/> Civilian <input type="checkbox"/> Police/Law Enforcement <input type="checkbox"/> Other _____							<b>Race</b> <input type="checkbox"/> 1 White <input type="checkbox"/> 2 Black <input type="checkbox"/> 3 Am. Indian <input type="checkbox"/> 4 Asian <input type="checkbox"/> 0 Other <input type="checkbox"/> U Undetermined				
<b>Date &amp; Time of Injury</b>		<b>Severity of Injury</b>			<b>Cause of Injury</b>						
____/____/____ <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat Time: _____ : _____		<input type="checkbox"/> 1 Minor <input type="checkbox"/> 2 Moderate <input type="checkbox"/> 3 Severe <input type="checkbox"/> 4 Life Threatening <input type="checkbox"/> 5 Death			<input type="checkbox"/> 1 Exposed to fire products including flame, heat, smoke & gas <input type="checkbox"/> 2 Exposed to toxic fumes other than smoke <input type="checkbox"/> 3 Jumped in escape attempt <input type="checkbox"/> 4 Fell, slipped, or tripped <input type="checkbox"/> 5 Caught or trapped <input type="checkbox"/> 6 Structural collapse <input type="checkbox"/> 7 Struck by/or contact with object <input type="checkbox"/> 8 Overexertion <input type="checkbox"/> 9 Multiple causes <input type="checkbox"/> O Other <input type="checkbox"/> U Undetermined						
<b>Human Factors Contributing to Injury</b> <input type="checkbox"/> None							<b>Location at Time of Incident</b>			<b>General Location at Time of Injury</b>	
<input type="checkbox"/> 1 Asleep <input type="checkbox"/> 2 Unconscious <input type="checkbox"/> 3 Possibly impaired by alcohol <input type="checkbox"/> 4 Possibly impaired by other drug <input type="checkbox"/> 5 Possibly mentally disabled <input type="checkbox"/> 6 Physically disabled <input type="checkbox"/> 7 Physically restrained <input type="checkbox"/> 8 Unattended person							<input type="checkbox"/> 1 In area of origin and not involved <input type="checkbox"/> 2 Not in area of origin & not involved <input type="checkbox"/> 3 Not in area of origin, but involved <input type="checkbox"/> 4 In area of origin and involved <input type="checkbox"/> U Undetermined			<input type="checkbox"/> 1 In area of fire origin <input type="checkbox"/> 2 In building, not in area <input type="checkbox"/> 3 Outside, not in area	
<b>Factors Contributing to Injury</b> <input type="checkbox"/> None							<b>Primary Apparent Symptom</b>				
<b>Activity When Injured</b>							<input type="checkbox"/> 01 Smoke only, asphyxiation <input type="checkbox"/> 11 Burns & smoke inhalation <input type="checkbox"/> 12 Burns only <input type="checkbox"/> 21 Cuts, laceration <input type="checkbox"/> 96 Shock <input type="checkbox"/> 33 Strain or sprain <input type="checkbox"/> 98 Pain only Other: _____			<input type="checkbox"/> <b>Disposition</b> <input type="checkbox"/> Transported to ER Facility: _____	
<b>Story at Start of Incident</b>		<b>Story where injury occurred</b>									
_____ <input type="checkbox"/> Check if Below Grade		_____ <input type="checkbox"/> Check if Below Grade									
<b>Specific Location at Time of Injury</b>		(Civilian)									
<b>Primary Area of Body Injured</b>		<input type="checkbox"/> 1 Head <input type="checkbox"/> 2 Neck & shoulder <input type="checkbox"/> 3 Thorax <input type="checkbox"/> 4 Abdomen <input type="checkbox"/> 5 Spine <input type="checkbox"/> 6 Upper extremities <input type="checkbox"/> 7 Lower extremities <input type="checkbox"/> 8 Internal <input type="checkbox"/> 9 Multiple body parts									
<b>Remarks</b>											
<b>FOLLOWING ITEMS ARE FOR FIRE SERVICE CASUALTY REPORT USE ONLY</b>											
<b>Responses</b>		<b>Usual Assignment</b>									
Responses made in past 24 hrs		<input type="checkbox"/> 1 Suppression <input type="checkbox"/> 2 EMS <input type="checkbox"/> 3 Prevention <input type="checkbox"/> 4 Training <input type="checkbox"/> 5 Maintenance <input type="checkbox"/> 6 Communications <input type="checkbox"/> 7 Administration <input type="checkbox"/> 8 Fire Investigation <input type="checkbox"/> 0 Other									
<b>Physical Condition Just Prior to Injury</b>					<b>Severity</b>						
<input type="checkbox"/> 1 Rested <input type="checkbox"/> 2 Fatigued <input type="checkbox"/> 3 Ill or Injured <input type="checkbox"/> 0 Other <input type="checkbox"/> U Undetermined					<input type="checkbox"/> 1 Report only, including exposure <input type="checkbox"/> 2 First aid only <input type="checkbox"/> 3 Treatment by physician (no lost time) <input type="checkbox"/> 4 Moderate (lost time) <input type="checkbox"/> 5 Severe (lost time) <input type="checkbox"/> 6 Life threatening (lost time) <input type="checkbox"/> 7 Death						
<b>Taken To</b>											
<input type="checkbox"/> 1 Hospital <input type="checkbox"/> 4 Doctor's office <input type="checkbox"/> 5 Morgue/funeral home <input type="checkbox"/> 6 Residence <input type="checkbox"/> 7 Station/Quarters <input type="checkbox"/> 0 Other <input type="checkbox"/> N Not transported											
<b>Activity at Time of Injury</b>		<b>Primary Area of Body Injured</b>									
<b>Primary Apparent Symptom</b>		<b>Cause of Firefighter Injury</b>			<b>Factor Contributing to Injury</b>						
<i>Complete the Other Side</i>											

**\*\*\* Do Not Send To State Fire Marshal \*\*\***

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<b>Object Involved in Injury</b>	<b>Where Injury Occurred</b> 1 <input type="checkbox"/> Enroute to FD location    2 <input type="checkbox"/> At FD location 3 <input type="checkbox"/> Enroute to incident scene    4 <input type="checkbox"/> Enroute to medical facility    5 <input type="checkbox"/> At scene in structure 6 <input type="checkbox"/> At scene outside    7 <input type="checkbox"/> At medical facility    8 <input type="checkbox"/> Returning from incident
<b>Specific Location</b>	9 <input type="checkbox"/> Returning from medical facility    0 <input type="checkbox"/> Other _____    U <input type="checkbox"/> Undetermined
	22 <input type="checkbox"/> Outside at grade    23 <input type="checkbox"/> On roof    24 <input type="checkbox"/> On aerial ladder or basket    25 <input type="checkbox"/> On ground ladder    26 <input type="checkbox"/> On vertical surface or ledge 27 <input type="checkbox"/> On fire escape/outside stairs    28 <input type="checkbox"/> On steep grade    31 <input type="checkbox"/> In open pit    32 <input type="checkbox"/> In ditch or trench    33 <input type="checkbox"/> In quarry or mine 34 <input type="checkbox"/> In ravine    35 <input type="checkbox"/> In well    36 <input type="checkbox"/> In water    45 <input type="checkbox"/> In attic    49 <input type="checkbox"/> In structure    53 <input type="checkbox"/> In tunnel    54 <input type="checkbox"/> In sewer    61 <input type="checkbox"/> In motor vehicle 63 <input type="checkbox"/> In rail vehicle    64 <input type="checkbox"/> In boat, ship or barge    65 <input type="checkbox"/> In aircraft    OO <input type="checkbox"/> Other specific location    NN <input type="checkbox"/> No spec loc    UU <input type="checkbox"/> Undetermined
<b>Vehicle Type</b>	1 <input type="checkbox"/> Suppression vehicle    2 <input type="checkbox"/> EMS vehicle    3 <input type="checkbox"/> Other FD vehicle    4 <input type="checkbox"/> Non-FD vehicle    N <input type="checkbox"/> None or NA
<b>COMMENTS</b>	
<b>Did protective equipment fail and contribute to this injury?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>IF PROTECTIVE EQUIPMENT FAILURE DID CONTRIBUTE TO THIS INJURY - COMPLETE THE FOLLOWING</b>	
<b>Protective Equipment Item</b>	11 <input type="checkbox"/> Helmet    12 <input type="checkbox"/> Full face protector    13 <input type="checkbox"/> Partial face protector 14 <input type="checkbox"/> Goggles/eye protection    15 <input type="checkbox"/> Hood    16 <input type="checkbox"/> Ear protection    17 <input type="checkbox"/> Neck protector    10 <input type="checkbox"/> Head or face protection, other 21 <input type="checkbox"/> Protective coat    22 <input type="checkbox"/> Protective trousers    23 <input type="checkbox"/> Uniform shirt    24 <input type="checkbox"/> Uniform T-shirt    25 <input type="checkbox"/> Uniform trousers 26 <input type="checkbox"/> Uniform coat or jacket    27 <input type="checkbox"/> Overalls    28 <input type="checkbox"/> Apron or gown    20 <input type="checkbox"/> Coat, shirt or trousers, other 31 <input type="checkbox"/> Knee length boots with steel baseplate & toe    32 <input type="checkbox"/> Knee length boots with steel toes only 33 <input type="checkbox"/> 3/4 length boots w/ steel baseplate & toes    34 <input type="checkbox"/> 3/4 length boots with steel toes only    35 <input type="checkbox"/> Boots without steel baseplate & toes 36 <input type="checkbox"/> Safety shoes with steel baseplate & toes    37 <input type="checkbox"/> Safety shoes with steel toes    38 <input type="checkbox"/> Non-safety shoes    30 <input type="checkbox"/> Boots or shoes, other 41 <input type="checkbox"/> SCBA (Demand) open circuit    42 <input type="checkbox"/> SCBA (Positive Pressure) open circuit    43 <input type="checkbox"/> SCBA closed circuit    44 <input type="checkbox"/> Non-SCBA 45 <input type="checkbox"/> Cartridge respirator    46 <input type="checkbox"/> Dust or particle mask    40 <input type="checkbox"/> Respiratory protection, other 51 <input type="checkbox"/> Firefighter gloves w/wristlets    52 <input type="checkbox"/> Firefighter gloves without wristlets    53 <input type="checkbox"/> Work gloves    54 <input type="checkbox"/> Hazmat gloves 55 <input type="checkbox"/> Medical gloves    50 <input type="checkbox"/> Hand protection, other 61 <input type="checkbox"/> Proximity suit for entry    62 <input type="checkbox"/> Proximity suit non-entry    63 <input type="checkbox"/> Totally encapsulated, reuseable chemical suit 64 <input type="checkbox"/> Totally encapsulated,disposable chemical suit    65 <input type="checkbox"/> Partially encapsulated, reuseable chemical suit 66 <input type="checkbox"/> Partially encapsulated, disposable chemical suit    67 <input type="checkbox"/> Flash protection suit    68 <input type="checkbox"/> Flight or jump suit    69 <input type="checkbox"/> Brush suit 71 <input type="checkbox"/> Exposure suit    72 <input type="checkbox"/> Self-contained underwater breathing apparatus (SCUBA)    73 <input type="checkbox"/> Life preserver    74 <input type="checkbox"/> Life belt or ladder belt 75 <input type="checkbox"/> Personal alert safety system (PASS)    76 <input type="checkbox"/> Radio distress device    77 <input type="checkbox"/> Personal lighting    78 <input type="checkbox"/> Fire shelter or tent 79 <input type="checkbox"/> Vehicle safety belt    70 <input type="checkbox"/> Special equipment, other
<b>Protective Equipment Problem</b>	11 <input type="checkbox"/> Burned    12 <input type="checkbox"/> Melted    21 <input type="checkbox"/> Fractured,cracked or broken    22 <input type="checkbox"/> Punctured 23 <input type="checkbox"/> Scratched    24 <input type="checkbox"/> Knocked off    25 <input type="checkbox"/> Cut or ripped    31 <input type="checkbox"/> Trapped steam or hazardous gas    32 <input type="checkbox"/> Insuficient insulation 33 <input type="checkbox"/> Object fell in or onto equipment item    41 <input type="checkbox"/> Failed under impact    42 <input type="checkbox"/> Face piece or hose detached 43 <input type="checkbox"/> Exhalation valve inoperative or damaged    44 <input type="checkbox"/> Harness detached or separated    45 <input type="checkbox"/> Regulator failed to operate 46 <input type="checkbox"/> Regulator damaged by contact    47 <input type="checkbox"/> Problem with admissions valve    48 <input type="checkbox"/> Alarm failed to operate    49 <input type="checkbox"/> Alarm damaged by contact 51 <input type="checkbox"/> Supply cylinder/valve failed to operate    52 <input type="checkbox"/> Supply cylinder/valve damaged by contact    53 <input type="checkbox"/> Supply cylinder-insufficient air/oxygen 94 <input type="checkbox"/> Did not fit properly    95 <input type="checkbox"/> Not properly serviced or stored prior to use    97 <input type="checkbox"/> Not used as recommended by manufacturer 00 <input type="checkbox"/> Other equipment problem    NN <input type="checkbox"/> No protective equipment problem    UU <input type="checkbox"/> Undetermined protective equipment problem
<b>Equipment Manufacturer, Model &amp; Serial Number</b>	Model: _____
Manufacturer: _____	
Serial Number: _____	
<b>COMMENTS:</b>	
<b>Report By</b>	
<b>X</b> _____	<b>X</b> _____
<i>Officer In Charge</i>	<i>Person Making Report</i>
Date	