

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

NFIRS 5.0 FIELD CASUALTY FORM

FTA Consultants 4/04

FDID	INCIDENT NO.	EXP	Month	Day	Year	Day of Week	Alarm Time	Casualty #		
Alarm Location			<small>[Number/Street Name / Apartment #]</small>						County	TWP.
Injured Person [Name / Gender / Affiliation Information]							DOB	Age		
<small>First Name MI Last Name Suffix</small>							<small>____/____/____</small>		<small>____</small>	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> FIRE DEPT <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							Race			
							<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			
Date & Time of Injury		Severity of Injury			Cause of Injury					
<small>____/____/____</small>		<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					
Human Factors Contributing to Injury		<input type="checkbox"/> None			Location at Time of Incident					
<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					
Factors Contributing to Injury		<input type="checkbox"/> None			General Location at Time of Injury					
					<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					
Activity When Injured					Primary Apparent Symptom					
<input type="checkbox"/> 1 Escaping <input type="checkbox"/> 2 Rescue attempt <input type="checkbox"/> 3 Fire control <input type="checkbox"/> 4 Return to fire before control <input type="checkbox"/> 5 Return to fire after control <input type="checkbox"/> 6 Sleeping <input type="checkbox"/> 7 Unable to act <input type="checkbox"/> 8 Irrational act <input type="checkbox"/> O Other <input type="checkbox"/> U Undetermined					<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: _____					
Story at Start of Incident		Story where injury occurred			Disposition					
_____ <input type="checkbox"/> Check if Below Grade		_____ <input type="checkbox"/> Check if Below Grade			<input type="checkbox"/> [] Transported to ER Facility: _____					
Specific Location at Time of Injury		(Civilian)								
Primary Area of Body Injured		<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								
Remarks										
FOLLOWING ITEMS ARE FOR FIRE SERVICE CASUALTY REPORT USE ONLY										
Responses		Usual Assignment								
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"/> O Other								
Physical Condition Just Prior to Injury					Severity					
<input type="checkbox"/> 1 Rested <input type="checkbox"/> 2 Fatigued <input type="checkbox"/> 3 Ill or Injured <input type="checkbox"/> O 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					
Taken To										
<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"/> O Other <input type="checkbox"/> N Not transported										
Activity at Time of Injury		Primary Area of Body Injured								
Primary Apparent Symptom		Cause of Firefighter Injury			Factor Contributing to Injury					
<i>Complete the Other Side</i>										

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Object Involved in Injury	Where Injury Occurred 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
Specific Location	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
Vehicle Type	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
COMMENTS	
Did protective equipment fail and contribute to this injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF PROTECTIVE EQUIPMENT FAILURE DID CONTRIBUTE TO THIS INJURY - COMPLETE THE FOLLOWING	
Protective Equipment Item	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
Protective Equipment Problem	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
Equipment Manufacturer, Model & Serial Number	
Model: _____	
Manufacturer: _____	
Serial Number: _____	
COMMENTS:	
Report By	
X _____	X _____
<i>Officer In Charge</i>	<i>Person Making Report</i>
Date	