

**FIRE REPORT**

- All incidents of fire in an adult family home (AFH), a community based residential facility (CBRF), a facility serving people with developmental disabilities (FDD), a hospital, a nursing home, or a residential care apartment complex (RCAC) **must be reported to the Department of Health Services within 72 hours** per DHS 132.82(3)(e), DHS 134.82(3)(e), DHS 83.12(4)(e), DHS 124.36(11), DHS 88.05(4)(e), Wis. Administrative Code, and Chapter 50.035(4), Wis. Stats.
- Information about the fire may be reported by completing and submitting this form; however, it is not mandatory that you use this form.
- Include sketches, photographs, reports, or statements, if available.
- Questions about completion of this form may be directed to [DHSDQAPlanReview@wi.gov](mailto:DHSDQAPlanReview@wi.gov) or 608-264-7748.
- Mail the form and attachments to:

**FIRE AUTHORITY**  
**DQA / Office of Plan Review and Inspection**  
**P.O. Box 2969**  
**Madison, WI 53701-2969**

or email: [DHSDQAPlanReview@wi.gov](mailto:DHSDQAPlanReview@wi.gov)

or fax: 608-267-0352

Name – Facility		License / Provider Number
Address		City
Type of Provider <input type="checkbox"/> AFH <input type="checkbox"/> CBRF <input type="checkbox"/> FDD <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> RCAC <input type="checkbox"/> Other		
Date of Fire	Time of Fire <input type="checkbox"/> AM <input type="checkbox"/> PM	
Type of Fire <i>(Provide narrative description. Use the back of this form to provide additional information.)</i>		

Location of Fire in the Facility

Was anyone injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Number Injured	Number of Residents Injured	Number of Staff Injured	Number of Others Injured
Residents were evacuated from: <input type="checkbox"/> Room <input type="checkbox"/> Floor <input type="checkbox"/> Wing <input type="checkbox"/> Building			Were or are residents relocated to other facilities or locations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the fire alarm system activated? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Method of Activation</b> <input type="checkbox"/> Manual Pull Station <input type="checkbox"/> Heat Detector <input type="checkbox"/> Smoke Detector <input type="checkbox"/> Sprinkler System			
Number of Sprinkler Heads Activated	Was a follow-up call made to the fire department? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did the fire department respond? <input type="checkbox"/> Yes <input type="checkbox"/> No	
The fire was extinguished by: <input type="checkbox"/> Staff <input type="checkbox"/> Fire Dept. <input type="checkbox"/> Others		Method of Fire Extinguishment		
Is fire alarm system restored to normal working condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is sprinkler system restored to normal operational condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Estimated Cost of Repairs</b> \$

Name and Title – Person Completing This Report <i>(Print or type.)</i>	Telephone Number
<b>SIGNATURE</b> – Person Completing This Report	Date Report Completed