

NFIRS VERSION 5.0 DESIGN DOCUMENTATION

FIGURE 3-3. NFIRS-1 Basic Form (side 2)

K1 Person/Entity Involved											
Local Option		Business Name (if applicable)				Area Code		Phone Number			
<input type="checkbox"/> Check this box if same address as incident location (Section B). Then skip the three duplicate address lines.											
Mr., Ms., Mrs.		First Name			MI	Last Name			Suffix		
Number		Prefix	Street or Highway				Street Type		Suffix		
Post Office Box			Apt./Suite/Room			City					
State		ZIP Code									
<input type="checkbox"/> More people involved? Check this box and attach Supplemental Forms (NFIRS-1S) as necessary.											
K2 Owner											
Local Option		Business Name (if applicable)				Area Code		Phone Number			
<input type="checkbox"/> Same as person involved? Then check this box and skip the rest of this block.											
<input type="checkbox"/> Check this box if same address as incident location (Section B). Then skip the three duplicate address lines.											
Mr., Ms., Mrs.		First Name			MI	Last Name			Suffix		
Number		Prefix	Street or Highway				Street Type		Suffix		
Post Office Box			Apt./Suite/Room			City					
State		ZIP Code									
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Remarks: Local Option </div>											
<div style="border: 1px solid black; padding: 5px;"> Fire Module Required? Check the box that applies and then complete the Fire Module based on Incident Type, as follows: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Buildings 111 <input type="checkbox"/> Special structure 112 <input type="checkbox"/> Confined 113-118 <input type="checkbox"/> Mobile property 120-123 <input type="checkbox"/> Vehicle 130-138 <input type="checkbox"/> Vegetation 140-143 <input type="checkbox"/> Outside rubbish fire 150-155 <input type="checkbox"/> Special outside fire 160 <input type="checkbox"/> Special outside fire 161-163 <input type="checkbox"/> Crop fire 170-173 </td> <td style="width: 50%; vertical-align: top;"> Complete Fire & Structure Modules Complete Fire Module & Section I, Structure Module Basic Module Only Complete Fire & Structure Modules Complete Fire Module Complete Fire or Wildland Module Basic Module Only Complete Fire or Wildland Module Complete Fire Module Complete Fire or Wildland Module </td> </tr> </table> </div>										<input type="checkbox"/> Buildings 111 <input type="checkbox"/> Special structure 112 <input type="checkbox"/> Confined 113-118 <input type="checkbox"/> Mobile property 120-123 <input type="checkbox"/> Vehicle 130-138 <input type="checkbox"/> Vegetation 140-143 <input type="checkbox"/> Outside rubbish fire 150-155 <input type="checkbox"/> Special outside fire 160 <input type="checkbox"/> Special outside fire 161-163 <input type="checkbox"/> Crop fire 170-173	Complete Fire & Structure Modules Complete Fire Module & Section I, Structure Module Basic Module Only Complete Fire & Structure Modules Complete Fire Module Complete Fire or Wildland Module Basic Module Only Complete Fire or Wildland Module Complete Fire Module Complete Fire or Wildland Module
<input type="checkbox"/> Buildings 111 <input type="checkbox"/> Special structure 112 <input type="checkbox"/> Confined 113-118 <input type="checkbox"/> Mobile property 120-123 <input type="checkbox"/> Vehicle 130-138 <input type="checkbox"/> Vegetation 140-143 <input type="checkbox"/> Outside rubbish fire 150-155 <input type="checkbox"/> Special outside fire 160 <input type="checkbox"/> Special outside fire 161-163 <input type="checkbox"/> Crop fire 170-173	Complete Fire & Structure Modules Complete Fire Module & Section I, Structure Module Basic Module Only Complete Fire & Structure Modules Complete Fire Module Complete Fire or Wildland Module Basic Module Only Complete Fire or Wildland Module Complete Fire Module Complete Fire or Wildland Module										
<div style="display: flex; align-items: center;"> <div> ITEMS WITH A ★ MUST ALWAYS BE COMPLETED! </div> </div>											
<input type="checkbox"/> More remarks? Check this box and attach Supplemental Forms (NFIRS-1S) as necessary.											
M Authorization											
Check box if same as Officer in charge → <input type="checkbox"/>		Officer in charge ID		Signature		Position or rank		Assignment			
Month		Day		Year		Month		Day			
Year		Member making report ID		Signature		Position or rank		Assignment			
Month		Day		Year		Month		Day			
Year											

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FIGURE 3-5. NFIRS-3 Structure Fire Form

I1 Structure Type ☆ If fire was in an enclosed building or a portable/mobile structure, complete the rest of this form. <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> Enclosed building 2 <input type="checkbox"/> Portable/mobile structure 3 <input type="checkbox"/> Open structure 4 <input type="checkbox"/> Air-supported structure 5 <input type="checkbox"/> Tent 6 <input type="checkbox"/> Open platform (e.g., piers) 7 <input type="checkbox"/> Underground structure (work areas) 8 <input type="checkbox"/> Connective structure (e.g., fences) 0 <input type="checkbox"/> Other type of structure </div>		I2 Building Status ☆ <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> Under construction 2 <input type="checkbox"/> Occupied & operating 3 <input type="checkbox"/> Idle, not routinely used 4 <input type="checkbox"/> Under major renovation 5 <input type="checkbox"/> Vacant and secured 6 <input type="checkbox"/> Vacant and unsecured 7 <input type="checkbox"/> Being demolished 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined </div>		I3 Building Height ☆ Count the roof as part of the highest story. <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ Total number of stories at or above grade. </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ Total number of stories below grade. </div>		I4 Main Floor Size ☆ <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ , _____ , _____ Total square feet </div> <div style="text-align: center; margin: 10px 0;">OR</div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ , _____ BY _____ , _____ Length in feet Width in feet </div>		NFIRS-3 Structure Fire	
J1 Fire Origin ☆ <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ Story of fire origin </div> <div style="margin-top: 5px;"> <input type="checkbox"/> Below grade </div>		J3 Number of Stories Damaged by Flame Count the roof as part of the highest story. <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ Number of stories w/minor damage (1 to 24% flame damage) </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ Number of stories w/significant damage (25 to 49% flame damage) </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ Number of stories w/heavy damage (50 to 74% flame damage) </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ Number of stories w/extreme damage (75 to 100% flame damage) </div>		K Type of Material Contributing Most to Flame Spread <input type="checkbox"/> Check if no flame spread OR if same as Material First Ignited (Block D4, Fire Module) OR if unable to determine. <div style="border: 1px solid black; padding: 2px; margin-top: 5px; float: right;"> Skip to Section L </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> K1 _____ Item contributing most to flame spread </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> K2 _____ Type of material contributing most to flame spread </div> <div style="margin-top: 5px;"> Required only if item contributing code is 00 or <70. </div>					
J2 Fire Spread ☆ If fire spread was confined to object of origin, do not check a box (Ref. Block D3, Fire Module). <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 2 <input type="checkbox"/> Confined to room of origin 3 <input type="checkbox"/> Confined to floor of origin 4 <input type="checkbox"/> Confined to building of origin 5 <input type="checkbox"/> Beyond building of origin </div>		L1 Presence of Detectors ☆ (In area of the fire) <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> N <input type="checkbox"/> None Present 1 <input type="checkbox"/> Present U <input type="checkbox"/> Undetermined </div> <div style="margin-top: 5px; text-align: right;"> Skip to Section M </div>		L3 Detector Power Supply <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> Battery only 2 <input type="checkbox"/> Hardwire only 3 <input type="checkbox"/> Plug-in 4 <input type="checkbox"/> Hardwire with battery 5 <input type="checkbox"/> Plug-in with battery 6 <input type="checkbox"/> Mechanical 7 <input type="checkbox"/> Multiple detectors & power supplies 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined </div>		L5 Detector Effectiveness Required if detector operated. <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> Alerted occupants, occupants responded 2 <input type="checkbox"/> Alerted occupants, occupants failed to respond 3 <input type="checkbox"/> There were no occupants 4 <input type="checkbox"/> Failed to alert occupants U <input type="checkbox"/> Undetermined </div>			
L2 Detector Type <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> Smoke 2 <input type="checkbox"/> Heat 3 <input type="checkbox"/> Combination smoke and heat 4 <input type="checkbox"/> Sprinkler, water flow detection 5 <input type="checkbox"/> More than one type present 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined </div>		L4 Detector Operation <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> Fire too small to activate 2 <input type="checkbox"/> Operated 3 <input type="checkbox"/> Failed to operate U <input type="checkbox"/> Undetermined </div> <div style="margin-top: 5px; text-align: right;"> Complete Block L5 Complete Block L6 </div>		L6 Detector Failure Reason Required if detector failed to operate. <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> Power failure, shutoff, or disconnect 2 <input type="checkbox"/> Improper installation or placement 3 <input type="checkbox"/> Defective 4 <input type="checkbox"/> Lack of maintenance, includes not cleaning 5 <input type="checkbox"/> Battery missing or disconnected 6 <input type="checkbox"/> Battery discharged or dead 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined </div>					
M1 Presence of Automatic Extinguishing System ☆ <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> N <input type="checkbox"/> None Present 1 <input type="checkbox"/> Present 2 <input type="checkbox"/> Partial System Present U <input type="checkbox"/> Undetermined </div> <div style="margin-top: 5px; text-align: right;"> Complete rest of Section M </div>		M3 Operation of Automatic Extinguishing System Required if fire was within designed range. <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> Operated/effective (go to M4) 2 <input type="checkbox"/> Operated/Not effective (go to M4) 3 <input type="checkbox"/> Fire too small to activate 4 <input type="checkbox"/> Failed to operate (go to M5) 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined </div>		M5 Reason for Automatic Extinguishing System Failure Required if system failed or not effective. <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> System shut off 2 <input type="checkbox"/> Not enough agent discharged 3 <input type="checkbox"/> Agent discharged but did not reach fire 4 <input type="checkbox"/> Wrong type of system 5 <input type="checkbox"/> Fire not in area protected 6 <input type="checkbox"/> System components damaged 7 <input type="checkbox"/> Lack of maintenance 8 <input type="checkbox"/> Manual intervention 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined </div>					
M2 Type of Automatic Extinguishing System Required if fire was within designed range of AES. <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> 1 <input type="checkbox"/> Wet-pipe sprinkler 2 <input type="checkbox"/> Dry-pipe sprinkler 3 <input type="checkbox"/> Other sprinkler system 4 <input type="checkbox"/> Dry chemical system 5 <input type="checkbox"/> Foam system 6 <input type="checkbox"/> Halogen-type system 7 <input type="checkbox"/> Carbon dioxide (CO₂) system 0 <input type="checkbox"/> Other special hazard system U <input type="checkbox"/> Undetermined </div>		M4 Number of Sprinkler Heads Operating Required if system operated. <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> _____ Number of sprinkler heads operating </div>							

NFIRS-3 Revision 01/01/06

FIGURE 3-6. NFIRS-4 Civilian Fire Casualty Form

A FDID <input type="text"/> State <input type="text"/> Incident Date <input type="text"/> Station <input type="text"/> Incident Number <input type="text"/> Exposure <input type="text"/> <div style="float: right;"> <input type="checkbox"/> Delete <input type="checkbox"/> Change </div>		NFIRS-4 Civilian Fire Casualty	
B Injured Person First Name <input type="text"/> MI <input type="text"/> Last Name <input type="text"/> Suffix <input type="text"/>		C Casualty Number <input type="text"/>	
D Age or Date of Birth Age <input type="text"/> Months (for infants) <input type="checkbox"/> OR Date of Birth Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>		E1 Race 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black, African American 3 <input type="checkbox"/> Am. Indian, Alaska Native 4 <input type="checkbox"/> Asian 5 <input type="checkbox"/> Native Hawaiian, Other Pacific Islander 0 <input type="checkbox"/> Other, multiracial U <input type="checkbox"/> Undetermined E2 Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 0 <input type="checkbox"/> Non Hispanic or Latino	
F Affiliation 1 <input type="checkbox"/> Civilian 2 <input type="checkbox"/> EMS, not fire department 3 <input type="checkbox"/> Police 0 <input type="checkbox"/> Other		H Severity 1 <input type="checkbox"/> Minor 2 <input type="checkbox"/> Moderate 3 <input type="checkbox"/> Severe 4 <input type="checkbox"/> Life threatening 5 <input type="checkbox"/> Death U <input type="checkbox"/> Undetermined	
G Date and Time of Injury Date of Injury <input type="text"/> Time of Injury <input type="text"/>		Midnight is 0000. Date of Injury <input type="text"/> Time of Injury <input type="text"/>	
I Cause of Injury 1 <input type="checkbox"/> Exposed to fire products including flame heat, smoke, and gas 2 <input type="checkbox"/> Exposed to toxic fumes other than smoke 3 <input type="checkbox"/> Jumped in escape attempt 4 <input type="checkbox"/> Fell, slipped, or tripped 5 <input type="checkbox"/> Caught or trapped 6 <input type="checkbox"/> Structural collapse 7 <input type="checkbox"/> Struck by or contact with object 8 <input type="checkbox"/> Overexertion or strain 9 <input type="checkbox"/> Multiple causes 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined		J Human Factors Contributing to Injury <input type="checkbox"/> None Check all applicable boxes 1 <input type="checkbox"/> Asleep 2 <input type="checkbox"/> Unconscious 3 <input type="checkbox"/> Possibly impaired by alcohol 4 <input type="checkbox"/> Possibly impaired by other drug 5 <input type="checkbox"/> Possibly mentally disabled 6 <input type="checkbox"/> Physically disabled 7 <input type="checkbox"/> Physically restrained 8 <input type="checkbox"/> Unattended person	
K Factors Contributing to Injury <input type="checkbox"/> None Enter up to three contributing factors Contributing factor (1) <input type="text"/> Contributing factor (2) <input type="text"/> Contributing factor (3) <input type="text"/>		L Activity When Injured 1 <input type="checkbox"/> Escaping 2 <input type="checkbox"/> Rescue attempt 3 <input type="checkbox"/> Fire control 4 <input type="checkbox"/> Return to fire before control 5 <input type="checkbox"/> Return to fire after control 6 <input type="checkbox"/> Sleeping 7 <input type="checkbox"/> Unable to act 8 <input type="checkbox"/> Irrational act 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined	
M1 Location at Time of Incident 1 <input type="checkbox"/> In area of origin and not involved 2 <input type="checkbox"/> Not in area of origin and not involved 3 <input type="checkbox"/> Not in area of origin, but involved 4 <input type="checkbox"/> In area of origin and involved 0 <input type="checkbox"/> Other location U <input type="checkbox"/> Undetermined		M3 Story at Start of Incident Complete ONLY if injury occurred INSIDE Story at start of incident <input type="text"/> <input type="checkbox"/> Below grade	
M2 General Location at Time of Injury 1 <input type="checkbox"/> In area of fire origin → Skip to Section N 2 <input type="checkbox"/> In building, but not in area → Skip to Block M5 3 <input type="checkbox"/> Outside, but not in area → Skip to Block M5 U <input type="checkbox"/> Undetermined		M4 Story Where Injury Occurred Story where injury occurred, if different from M3 <input type="text"/> <input type="checkbox"/> Below grade	
M5 Specific Location at Time of Injury Complete ONLY if casualty NOT in area of origin Specific location at time of injury <input type="text"/>		N Primary Apparent Symptom 01 <input type="checkbox"/> Smoke only, asphyxiation 11 <input type="checkbox"/> Burns and smoke inhalation 12 <input type="checkbox"/> Burns only 21 <input type="checkbox"/> Cut, laceration 33 <input type="checkbox"/> Strain or sprain 96 <input type="checkbox"/> Shock 98 <input type="checkbox"/> Pain only Look up a code only if the symptom is NOT found above Primary apparent symptom <input type="text"/>	
O Primary Area of Body Injured 1 <input type="checkbox"/> Head 2 <input type="checkbox"/> Neck and shoulder 3 <input type="checkbox"/> Thorax 4 <input type="checkbox"/> Abdomen 5 <input type="checkbox"/> Spine 6 <input type="checkbox"/> Upper extremities 7 <input type="checkbox"/> Lower extremities 8 <input type="checkbox"/> Internal 9 <input type="checkbox"/> Multiple body parts		P Disposition <input type="checkbox"/> Transported to emergency care facility Remarks <input type="text"/> Local option	

NFIRS-4 Revision 01/01/04

FIGURE 3-7. NFIRS-5 Fire Service Casualty Form

NFIRS-5 Fire Service Casualty		
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <div style="display: flex; justify-content: space-between; margin-bottom: 5px;"> FDID <input type="text"/> State <input type="text"/> Incident Date <input type="text"/> Station <input type="text"/> Incident Number <input type="text"/> Exposure <input type="text"/> </div> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Delete <input type="checkbox"/> Change </div> </div> <div style="width: 15%; text-align: center;"> <input type="checkbox"/> </div> </div>		
B Injured Person <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> <input type="text"/> <small>Identification Number</small> </div> <div style="width: 35%;"> 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> 1 <input type="checkbox"/> Career 2 <input type="checkbox"/> Volunteer </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> <input type="text"/> <small>First Name</small> </div> <div style="width: 10%; text-align: center;"> <input type="text"/> <small>MI</small> </div> <div style="width: 25%; text-align: center;"> <input type="text"/> <small>Last Name</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> <input type="text"/> <small>Suffix</small> </div> </div>	C Casualty Number <input type="text"/> <small>Casualty Number</small>	
D Age or Date of Birth <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 40%;"> Age <input type="text"/> <small>In years</small> </div> <div style="width: 10%; text-align: center;"> OR </div> <div style="width: 45%;"> Date of Birth <input type="text"/> <small>Month</small> <input type="text"/> <small>Day</small> <input type="text"/> <small>Year</small> </div> </div>	E Date and Time of Injury <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> Date of Injury <input type="text"/> <small>Month</small> <input type="text"/> <small>Day</small> <input type="text"/> <small>Year</small> </div> <div style="width: 50%;"> Time of Injury <input type="text"/> <small>Hour</small> <input type="text"/> <small>Minute</small> </div> </div>	F Responses <input type="text"/> <small>Number of prior responses during past 24 hours</small>
G1 Usual Assignment 1 <input type="checkbox"/> Suppression 2 <input type="checkbox"/> EMS 3 <input type="checkbox"/> Prevention 4 <input type="checkbox"/> Training 5 <input type="checkbox"/> Maintenance 6 <input type="checkbox"/> Communications 7 <input type="checkbox"/> Administration 8 <input type="checkbox"/> Fire investigation 0 <input type="checkbox"/> Other	G2 Physical Condition Just Prior to Injury 1 <input type="checkbox"/> Rested 2 <input type="checkbox"/> Fatigued 4 <input type="checkbox"/> Ill or injured 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined	G4 Taken To <input type="checkbox"/> Not transported 1 <input type="checkbox"/> Hospital 4 <input type="checkbox"/> Doctor's office 5 <input type="checkbox"/> Morgue/Funeral home 6 <input type="checkbox"/> Residence 7 <input type="checkbox"/> Station or quarters 0 <input type="checkbox"/> Other G5 Activity at Time of Injury <input type="text"/> <small>Activity at time of injury</small>
H1 Primary Apparent Symptom <input type="text"/> <small>Primary apparent symptom</small>	I1 Cause of Firefighter Injury <input type="text"/> <small>Cause of injury</small>	I3 Object Involved in Injury <input type="checkbox"/> None <input type="text"/> <small>Object involved in injury</small>
H2 Primary Part of Body Injured <input type="checkbox"/> None <input type="text"/> <small>Primary injured body part</small>	I2 Factor Contributing to Injury <input type="checkbox"/> None <input type="text"/> <small>Contributing factor</small>	
J1 Where Injury Occurred 1 <input type="checkbox"/> En route to FD location 2 <input type="checkbox"/> At FD location 3 <input type="checkbox"/> En route to incident scene 4 <input type="checkbox"/> En route 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 9 <input type="checkbox"/> Returning from med facility 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined	J3 Specific Location Where Injury Occurred <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> 65 <input type="checkbox"/> In aircraft 64 <input type="checkbox"/> In boat, ship, or barge 63 <input type="checkbox"/> In rail vehicle 61 <input type="checkbox"/> In motor vehicle 54 <input type="checkbox"/> In sewer 53 <input type="checkbox"/> In tunnel 49 <input type="checkbox"/> In structure 45 <input type="checkbox"/> In attic 36 <input type="checkbox"/> In water 35 <input type="checkbox"/> In well 34 <input type="checkbox"/> In ravine 33 <input type="checkbox"/> In quarry or mine 32 <input type="checkbox"/> In ditch or trench 31 <input type="checkbox"/> In open pit 28 <input type="checkbox"/> On steep grade 27 <input type="checkbox"/> On fire escape/outside stairs 26 <input type="checkbox"/> On vertical surface or ledge 25 <input type="checkbox"/> On ground ladder 24 <input type="checkbox"/> On aerial ladder or in basket 23 <input type="checkbox"/> On roof 22 <input type="checkbox"/> Outside at grade </div> <div style="width: 35%;"> 00 <input type="checkbox"/> Other UU <input type="checkbox"/> Undetermined </div> </div>	J4 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 Remarks <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
J2 Story Where Injury Occurred 1 <input type="checkbox"/> Check this box and enter the story if the injury occurred inside or on a structure <input type="text"/> <small>Story of injury</small> <input type="checkbox"/> Below grade 2 <input type="checkbox"/> Injury occurred outside	<div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> If protective equipment failed and was a factor in this injury, please complete the other side of this form. </div>	

FIGURE 3-8. NFIRS-5 Fire Service Casualty Form (side 2)

K1 Did protective equipment fail and contribute to the injury? Please complete the remainder of this form ONLY if you answer YES.		Yes <input type="checkbox"/> Y No <input type="checkbox"/> N	Equipment Sequence Number 	NFIRS-5 Fire Service Casualty
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K2 Protective Equipment Item	K3 Protective Equipment Problem Check one box to indicate the main problem that occurred.
<div style="margin-bottom: 10px;"> Head or Face Protection </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> 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 protector 17 <input type="checkbox"/> Neck protector 18 <input type="checkbox"/> Other </div> <div style="width: 48%;"> Coat, Shirt, or Trousers 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"/> Coveralls 28 <input type="checkbox"/> Apron or gown 29 <input type="checkbox"/> Other </div> </div> <div style="margin-bottom: 10px;"> Boots or Shoes </div> <div> 31 <input type="checkbox"/> Knee length boots with steel baseplate and steel toes 32 <input type="checkbox"/> Knee length boots with steel toes only 33 <input type="checkbox"/> 3/4 length boots with steel baseplate and steel toes 34 <input type="checkbox"/> 3/4 length boots with steel toes only 35 <input type="checkbox"/> Boots without steel baseplate and steel toes 36 <input type="checkbox"/> Safety shoes with steel baseplate and steel toes 37 <input type="checkbox"/> Safety shoes with steel toes only 38 <input type="checkbox"/> Non-safety shoes 39 <input type="checkbox"/> Other </div> <div style="margin-bottom: 10px;"> Respiratory Protection </div> <div> 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"/> Not self-contained 45 <input type="checkbox"/> Cartridge respirator 46 <input type="checkbox"/> Dust or particle mask 47 <input type="checkbox"/> Other </div> <div style="margin-bottom: 10px;"> Hand Protection </div> <div> 51 <input type="checkbox"/> Firefighter gloves with 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 56 <input type="checkbox"/> Other </div> <div style="margin-bottom: 10px;"> Special Equipment </div> <div> 61 <input type="checkbox"/> Proximity suit for entry 62 <input type="checkbox"/> Proximity suit for non-entry 63 <input type="checkbox"/> Totally encapsulated, reusable chemical suit 64 <input type="checkbox"/> Totally encapsulated, disposable chemical suit 65 <input type="checkbox"/> Partially encapsulated, reusable 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 80 <input type="checkbox"/> Special equipment, other 81 <input type="checkbox"/> Protective equipment, other </div>	<div style="margin-bottom: 10px;"> 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"/> Insufficient 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 or 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 96 <input type="checkbox"/> Not used for designed purpose 97 <input type="checkbox"/> Not used as recommended by manufacturer 00 <input type="checkbox"/> Other equipment problem UU <input type="checkbox"/> Undetermined </div> <div style="margin-bottom: 10px;"> K4 Equipment Manufacturer, Model and Serial Number </div> <div style="margin-bottom: 10px;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="font-size: small; margin-top: 2px;">Manufacturer</div> </div> <div style="margin-bottom: 10px;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="font-size: small; margin-top: 2px;">Model</div> </div> <div style="margin-bottom: 10px;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="font-size: small; margin-top: 2px;">Serial Number</div> </div> <div style="font-size: x-small; text-align: right;">NFIRS-5 Revision 05/01/03</div>

Was the failure of more than one item of protective equipment a factor in the injury? If so, complete an additional page of this form for each piece of failed equipment.

FIGURE 3-9. NFIRS-6 Emergency Medical Services (EMS) Form

A FDID State Incident Date Station Incident Number Exposure		<input type="checkbox"/> Delete <input type="checkbox"/> Change	NFIRS-6 EMS																																
B Number of Patients Patient Number		C Date/Time Month Day Year Hour/Min																																	
Use a separate form for each patient		<input type="checkbox"/> Time Arrived at Patient <input type="checkbox"/> Time of Patient Transfer																																	
D Provider Impression/Assessment <input type="checkbox"/> Check one box only <input type="checkbox"/> None/no patient or refused treatment																																			
<table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Abdominal pain</td> <td><input type="checkbox"/> Chest pain</td> <td><input type="checkbox"/> Hypovolemia</td> <td><input type="checkbox"/> Sexual assault</td> </tr> <tr> <td><input type="checkbox"/> Airway obstruction</td> <td><input type="checkbox"/> Diabetic symptom</td> <td><input type="checkbox"/> Inhalation injury</td> <td><input type="checkbox"/> Sting/Bite</td> </tr> <tr> <td><input type="checkbox"/> Allergic reaction</td> <td><input type="checkbox"/> Do not resuscitate</td> <td><input type="checkbox"/> Obvious death</td> <td><input type="checkbox"/> Stroke/CVA</td> </tr> <tr> <td><input type="checkbox"/> Altered LOC</td> <td><input type="checkbox"/> Electrocutation</td> <td><input type="checkbox"/> OD/Poisoning</td> <td><input type="checkbox"/> Syncope</td> </tr> <tr> <td><input type="checkbox"/> Behavioral/Psych</td> <td><input type="checkbox"/> General illness</td> <td><input type="checkbox"/> Pregnancy/OB</td> <td><input type="checkbox"/> Trauma</td> </tr> <tr> <td><input type="checkbox"/> Burns</td> <td><input type="checkbox"/> Hemorrhaging/Bleeding</td> <td><input type="checkbox"/> Respiratory arrest</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Cardiac arrest</td> <td><input type="checkbox"/> Hyperthermia</td> <td><input type="checkbox"/> Respiratory distress</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Cardiac dysrhythmia</td> <td><input type="checkbox"/> Hypothermia</td> <td><input type="checkbox"/> Seizure</td> <td></td> </tr> </table>				<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hypovolemia	<input type="checkbox"/> Sexual assault	<input type="checkbox"/> Airway obstruction	<input type="checkbox"/> Diabetic symptom	<input type="checkbox"/> Inhalation injury	<input type="checkbox"/> Sting/Bite	<input type="checkbox"/> Allergic reaction	<input type="checkbox"/> Do not resuscitate	<input type="checkbox"/> Obvious death	<input type="checkbox"/> Stroke/CVA	<input type="checkbox"/> Altered LOC	<input type="checkbox"/> Electrocutation	<input type="checkbox"/> OD/Poisoning	<input type="checkbox"/> Syncope	<input type="checkbox"/> Behavioral/Psych	<input type="checkbox"/> General illness	<input type="checkbox"/> Pregnancy/OB	<input type="checkbox"/> Trauma	<input type="checkbox"/> Burns	<input type="checkbox"/> Hemorrhaging/Bleeding	<input type="checkbox"/> Respiratory arrest	<input type="checkbox"/> Other	<input type="checkbox"/> Cardiac arrest	<input type="checkbox"/> Hyperthermia	<input type="checkbox"/> Respiratory distress		<input type="checkbox"/> Cardiac dysrhythmia	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Seizure	
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hypovolemia	<input type="checkbox"/> Sexual assault																																
<input type="checkbox"/> Airway obstruction	<input type="checkbox"/> Diabetic symptom	<input type="checkbox"/> Inhalation injury	<input type="checkbox"/> Sting/Bite																																
<input type="checkbox"/> Allergic reaction	<input type="checkbox"/> Do not resuscitate	<input type="checkbox"/> Obvious death	<input type="checkbox"/> Stroke/CVA																																
<input type="checkbox"/> Altered LOC	<input type="checkbox"/> Electrocutation	<input type="checkbox"/> OD/Poisoning	<input type="checkbox"/> Syncope																																
<input type="checkbox"/> Behavioral/Psych	<input type="checkbox"/> General illness	<input type="checkbox"/> Pregnancy/OB	<input type="checkbox"/> Trauma																																
<input type="checkbox"/> Burns	<input type="checkbox"/> Hemorrhaging/Bleeding	<input type="checkbox"/> Respiratory arrest	<input type="checkbox"/> Other																																
<input type="checkbox"/> Cardiac arrest	<input type="checkbox"/> Hyperthermia	<input type="checkbox"/> Respiratory distress																																	
<input type="checkbox"/> Cardiac dysrhythmia	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Seizure																																	
E1 Age or Date of Birth <input type="checkbox"/> Months (for infants)		F1 Race																																	
Age OR Month Day Year		1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black, African American 3 <input type="checkbox"/> Am. Indian, Alaska Native 4 <input type="checkbox"/> Asian 5 <input type="checkbox"/> Native Hawaiian, Other Pacific Islander 0 <input type="checkbox"/> Other, multiracial U <input type="checkbox"/> Undetermined																																	
E2 Gender 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female		F2 Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Non Hispanic or Latino																																	
G1 Human Factors Contributing to Injury <input type="checkbox"/> None		G2 Other Factors <input type="checkbox"/> None																																	
Check all applicable boxes 1 <input type="checkbox"/> Asleep 2 <input type="checkbox"/> Unconscious 3 <input type="checkbox"/> Possibly impaired by alcohol 4 <input type="checkbox"/> Possibly impaired by drug 5 <input type="checkbox"/> Possibly mentally disabled 6 <input type="checkbox"/> Physically disabled 7 <input type="checkbox"/> Physically restrained 8 <input type="checkbox"/> Unattended person		If an illness, not an injury, skip G2 and go to H3 1 <input type="checkbox"/> Accidental 2 <input type="checkbox"/> Self-inflicted 3 <input type="checkbox"/> Inflicted, not self																																	
H1 Body Site of Injury List up to five body sites		H2 Injury Type List one injury type for each body site listed under H1																																	
_____ _____ _____ _____ _____		_____ _____ _____ _____ _____																																	
H3 Cause of Illness/Injury Cause of illness/Injury		_____ _____																																	
I Procedures Used Check all applicable boxes <input type="checkbox"/> No treatment		J Safety Equipment <input type="checkbox"/> None																																	
01 <input type="checkbox"/> Airway insertion 14 <input type="checkbox"/> Intubation (EGTA) 02 <input type="checkbox"/> Anti-shock trousers 15 <input type="checkbox"/> Intubation (ET) 03 <input type="checkbox"/> Assist ventilation 16 <input type="checkbox"/> IO/IV therapy 04 <input type="checkbox"/> Bleeding control 17 <input type="checkbox"/> Medications therapy 05 <input type="checkbox"/> Burn care 18 <input type="checkbox"/> Oxygen therapy 06 <input type="checkbox"/> Cardiac pacing 19 <input type="checkbox"/> OB care/delivery 07 <input type="checkbox"/> Cardioversion (defib) manual 20 <input type="checkbox"/> Prearrival instructions 08 <input type="checkbox"/> Chest/Abdominal thrust 21 <input type="checkbox"/> Restrain patient 09 <input type="checkbox"/> CPR 22 <input type="checkbox"/> Spinal immobilization 10 <input type="checkbox"/> Cricothyroidotomy 23 <input type="checkbox"/> Splinted extremities 11 <input type="checkbox"/> Defibrillation by AED 24 <input type="checkbox"/> Suction/Aspirate 12 <input type="checkbox"/> EKG monitoring 00 <input type="checkbox"/> Other 13 <input type="checkbox"/> Extrication		Used or deployed by patient. Check all applicable boxes. 1 <input type="checkbox"/> Safety/Seat belts 2 <input type="checkbox"/> Child safety seat 3 <input type="checkbox"/> Airbag 4 <input type="checkbox"/> Helmet 5 <input type="checkbox"/> Protective clothing 6 <input type="checkbox"/> Flotation device 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined																																	
K Cardiac Arrest Check all applicable boxes		L Initial Level of Provider <input type="checkbox"/> No Training																																	
1 <input type="checkbox"/> Pre-arrival arrest? If pre-arrival arrest, was it: 1 <input type="checkbox"/> Witnessed? 2 <input type="checkbox"/> Bystander CPR? 2 <input type="checkbox"/> Post-arrival arrest? Initial Arrest Rhythm 1 <input type="checkbox"/> V-Fib/V-Tach 0 <input type="checkbox"/> Other U <input type="checkbox"/> Undetermined		1 <input type="checkbox"/> First Responder 2 <input type="checkbox"/> EMT-B (Basic) 3 <input type="checkbox"/> EMT-I (Intermediate) 4 <input type="checkbox"/> EMT-P (Paramedic) 0 <input type="checkbox"/> Other provider N <input type="checkbox"/> No Training																																	
M Patient Status 1 <input type="checkbox"/> Improved 2 <input type="checkbox"/> Remained same 3 <input type="checkbox"/> Worsened		N EMS Disposition <input type="checkbox"/> Not transported																																	
Check if: 1 <input type="checkbox"/> Pulse on transfer 2 <input type="checkbox"/> No pulse on transfer		1 <input type="checkbox"/> FD transport to ECF 2 <input type="checkbox"/> Non-FD transport 3 <input type="checkbox"/> Non-FD trans/FD attend 4 <input type="checkbox"/> Non-emergency transfer 0 <input type="checkbox"/> Other																																	

FIGURE 3-10. NFIRS-7 Hazardous Materials (HazMat) Form

A FDID <input type="text"/> State <input type="text"/> Incident Date <input type="text"/> Station <input type="text"/> Incident Number <input type="text"/> Exposure <input type="text"/> Haz No <input type="text"/> <input type="checkbox"/> Delete <input type="checkbox"/> Change		NFIRS-7 HazMat	
B HazMat ID <input type="text"/> UN Number <input type="text"/> DOT Hazard Classification <input type="text"/> CAS Registration Number <input type="text"/> Chemical Name <input type="text"/>			
C1 Container Type <input type="checkbox"/> None <input type="text"/> Container Type	C2 Estimated Container Capacity <input type="text"/> , <input type="text"/> , <input type="text"/> Capacity: by volume or weight	D1 Estimated Amount Released <input type="checkbox"/> <input type="text"/> , <input type="text"/> , <input type="text"/> Amount released: by volume or weight	E1 Physical State When Released 1 <input type="checkbox"/> Solid 2 <input type="checkbox"/> Liquid 3 <input type="checkbox"/> Gas U <input type="checkbox"/> Undetermined
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> More hazardous materials? Use additional sheets. </div>	C3 Units: Capacity Check one box <div style="display: flex; justify-content: space-between;"> <div> VOLUME 11 <input type="checkbox"/> Ounces 12 <input type="checkbox"/> Gallons 13 <input type="checkbox"/> Barrels: 42 gal. 14 <input type="checkbox"/> Liters 15 <input type="checkbox"/> Cubic feet 16 <input type="checkbox"/> Cubic meters </div> <div> WEIGHT 21 <input type="checkbox"/> Ounces 22 <input type="checkbox"/> Pounds 23 <input type="checkbox"/> Grams 24 <input type="checkbox"/> Kilograms MICRO UNITS <input type="text"/> Enter Code </div> </div>	D2 Units: Released Check one box <div style="display: flex; justify-content: space-between;"> <div> VOLUME 11 <input type="checkbox"/> Ounces 12 <input type="checkbox"/> Gallons 13 <input type="checkbox"/> Barrels: 42 gal. 14 <input type="checkbox"/> Liters 15 <input type="checkbox"/> Cubic feet 16 <input type="checkbox"/> Cubic meters </div> <div> WEIGHT 21 <input type="checkbox"/> Ounces 22 <input type="checkbox"/> Pounds 23 <input type="checkbox"/> Grams 24 <input type="checkbox"/> Kilograms MICRO UNITS <input type="text"/> Enter Code </div> </div>	E2 Released Into <input type="text"/> Released into
	<div style="border: 1px solid black; padding: 5px; width: fit-content;"> Complete the remainder of this form only for the first hazardous material involved in this incident. </div>		
F1 Released From Check all applicable boxes <input type="checkbox"/> Below grade 1 <input type="checkbox"/> Inside/on structure <input type="text"/> Story of release 2 <input type="checkbox"/> Outside of structure	F2 Population Density 1 <input type="checkbox"/> Urban 2 <input type="checkbox"/> Suburban 3 <input type="checkbox"/> Rural	G2 Area Evacuated <input type="checkbox"/> None 1 <input type="checkbox"/> Square feet 2 <input type="checkbox"/> Blocks 3 <input type="checkbox"/> Square miles <input type="text"/> Enter measurement	H HazMat Actions Taken Enter up to three actions taken Primary action taken (1) <input type="text"/> Additional action taken (2) <input type="text"/> Additional action taken (3) <input type="text"/>
G1 Area Affected 1 <input type="checkbox"/> Square feet 2 <input type="checkbox"/> Blocks 3 <input type="checkbox"/> Square miles <input type="text"/> Enter measurement		G3 Estimated Number of People Evacuated <input type="text"/> , <input type="text"/>	I If fire or explosion is involved with a release, which occurred first? 1 <input type="checkbox"/> Ignition U <input type="checkbox"/> Undetermined 2 <input type="checkbox"/> Release
J Cause of Release <input type="checkbox"/> 1 <input type="checkbox"/> Intentional 2 <input type="checkbox"/> Unintentional release 3 <input type="checkbox"/> Container/Containment failure 4 <input type="checkbox"/> Act of nature 5 <input type="checkbox"/> Cause under investigation U <input type="checkbox"/> Cause undetermined after investigation		K Factors Contributing to Release Enter up to three contributing factors Factor contributing to release (1) <input type="text"/> Factor contributing to release (2) <input type="text"/> Factor contributing to release (3) <input type="text"/>	L Factors Affecting Mitigation <input type="checkbox"/> None Enter up to three factors or impediments that affected the mitigation of the incident. Factor or impediment (1) <input type="text"/> Factor or impediment (2) <input type="text"/> Factor or impediment (3) <input type="text"/>
M Equipment Involved in Release <input type="checkbox"/> None <input type="text"/> Equipment involved in release Brand <input type="text"/> Model <input type="text"/> Serial # <input type="text"/> Year <input type="text"/>	N Mobile Property Involved in Release <input type="checkbox"/> None <input type="text"/> Mobile property type <input type="text"/> Mobile property make Model <input type="text"/> Year <input type="text"/> License plate number <input type="text"/> State <input type="text"/> DOT number/ ICC number <input type="text"/>		O HazMat Disposition <input type="checkbox"/> 1 <input type="checkbox"/> Completed by fire service only 2 <input type="checkbox"/> Completed w/fire service present 3 <input type="checkbox"/> Released to local agency 4 <input type="checkbox"/> Released to county agency 5 <input type="checkbox"/> Released to State agency 6 <input type="checkbox"/> Released to Federal agency 7 <input type="checkbox"/> Released to private agency 8 <input type="checkbox"/> Released to property owner or manager
P HazMat Civilian Casualties <div style="display: flex; justify-content: space-around;"> Deaths <input type="text"/> Injuries <input type="text"/> </div> <div style="text-align: right; font-size: small;"> NFIRS-7 Revision 01/01/06 </div>			

NFIRS VERSION 5.0 DESIGN DOCUMENTATION

FIGURE 3-12. NFIRS-9 Apparatus or Resources Form

A <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="text-align: center;"> FDID <input type="text"/> </div> <div style="text-align: center;"> State <input type="text"/> </div> <div style="text-align: center;"> Incident Date <input type="text"/> MM <input type="text"/> DD <input type="text"/> YYYY <input type="text"/> </div> <div style="text-align: center;"> Station <input type="text"/> </div> <div style="text-align: center;"> Incident Number <input type="text"/> </div> <div style="text-align: center;"> Exposure <input type="text"/> </div> <div style="text-align: right;"> <input type="checkbox"/> Delete <input type="checkbox"/> Change </div> </div>										NFIRS-9 Apparatus or Resources	
B Apparatus or Resources <small>Use codes listed below</small>		Dates and Times <small>Midnight is 0000</small> <input type="checkbox"/> Check if same date as Alarm date on the Basic Module (Block E1). <div style="display: flex; justify-content: space-between;"> Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> Hour/Min <input type="text"/> </div>		Sent <input checked="" type="checkbox"/>	Number of People <input type="text"/>	Apparatus Use <input type="checkbox"/> <small>Check ONE box for each apparatus to indicate its main use at the incident.</small>		Actions Taken <small>List up to 4 actions for each apparatus.</small>			
1	ID <input type="text"/> Type <input type="text"/>	Dispatch <input type="checkbox"/> Arrival <input type="checkbox"/> Clear <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
2	ID <input type="text"/> Type <input type="text"/>	Dispatch <input type="checkbox"/> Arrival <input type="checkbox"/> Clear <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
3	ID <input type="text"/> Type <input type="text"/>	Dispatch <input type="checkbox"/> Arrival <input type="checkbox"/> Clear <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
4	ID <input type="text"/> Type <input type="text"/>	Dispatch <input type="checkbox"/> Arrival <input type="checkbox"/> Clear <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
5	ID <input type="text"/> Type <input type="text"/>	Dispatch <input type="checkbox"/> Arrival <input type="checkbox"/> Clear <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
6	ID <input type="text"/> Type <input type="text"/>	Dispatch <input type="checkbox"/> Arrival <input type="checkbox"/> Clear <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
7	ID <input type="text"/> Type <input type="text"/>	Dispatch <input type="checkbox"/> Arrival <input type="checkbox"/> Clear <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
8	ID <input type="text"/> Type <input type="text"/>	Dispatch <input type="checkbox"/> Arrival <input type="checkbox"/> Clear <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
9	ID <input type="text"/> Type <input type="text"/>	Dispatch <input type="checkbox"/> Arrival <input type="checkbox"/> Clear <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
Apparatus or Resource Type Ground Fire Suppression 11 Engine 12 Truck or aerial 13 Quint 14 Tanker and pumper combination 16 Brush truck 17 ARFF (aircraft rescue and firefighting) 10 Ground fire suppression, other Heavy Ground Equipment 21 Dozer or plow 22 Tractor 24 Tanker or tender 20 Heavy ground equipment, other		Aircraft 41 Aircraft: fixed-wing tanker 42 Helitanker 43 Helicopter 40 Aircraft, other Marine Equipment 51 Fire boat with pump 52 Boat, no pump 50 Marine equipment, other Support Equipment 61 Breathing apparatus support 62 Light and air unit 60 Support apparatus, other		Medical and Rescue 71 Rescue unit 72 Urban search and rescue unit 73 High-angle rescue unit 75 BLS unit 76 ALS unit 70 Medical and rescue unit, other Other 91 Mobile command post 92 Chief officer car 93 HazMat unit 94 Type I hand crew 95 Type II hand crew 99 Privately owned vehicle 00 Other apparatus/resources		<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> More apparatus? Use additional sheets. </div> <div style="display: flex; justify-content: space-between;"> NN None UU Undetermined </div>					

NFIRS-9 Revision 01/01/04

FIGURE 3-13. NFIRS-10 Personnel Form

A		FDID <input style="width: 40px;" type="text"/>		State <input style="width: 40px;" type="text"/>		Incident Date <input style="width: 40px;" type="text"/> MM <input style="width: 40px;" type="text"/> DD <input style="width: 40px;" type="text"/> YYYY <input style="width: 40px;" type="text"/>		Station <input style="width: 40px;" type="text"/>		Incident Number <input style="width: 40px;" type="text"/>		Exposure <input style="width: 40px;" type="text"/>		<input type="checkbox"/> Delete <input type="checkbox"/> Change		NFIRS-10 Personnel	
----------	--	--	--	---	--	--	--	---	--	---	--	--	--	--	--	-------------------------------	--

B		Apparatus or Resources		Dates and Times		Midnight is 0000 Check if same date as Alarm date on the Basic Module (Block E1) Month <input style="width: 40px;" type="text"/> Day <input style="width: 40px;" type="text"/> Year <input style="width: 40px;" type="text"/> Hour/Min <input style="width: 40px;" type="text"/>		Sent <input checked="" type="checkbox"/>		Number of People <input style="width: 40px;" type="text"/>		Apparatus Use <input checked="" type="checkbox"/>		Actions Taken	
1 ID <input style="width: 40px;" type="text"/> ☆ Type <input style="width: 40px;" type="text"/>		Dispatch <input type="checkbox"/> <input style="width: 40px;" type="text"/> Arrival <input type="checkbox"/> <input style="width: 40px;" type="text"/> Clear <input type="checkbox"/> <input style="width: 40px;" type="text"/>		Sent <input type="checkbox"/> Number of People <input style="width: 40px;" type="text"/>		Apparatus Use <input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other		List up to 4 actions for each apparatus and each personnel. <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>							

Personnel ID ☆	Name	Rank or Grade	Attend <input checked="" type="checkbox"/>	Action Taken	Action Taken	Action Taken	Action Taken
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				

2 ID <input style="width: 40px;" type="text"/> ☆ Type <input style="width: 40px;" type="text"/>		Dispatch <input type="checkbox"/> <input style="width: 40px;" type="text"/> Arrival <input type="checkbox"/> <input style="width: 40px;" type="text"/> Clear <input type="checkbox"/> <input style="width: 40px;" type="text"/>		Sent <input type="checkbox"/> Number of People <input style="width: 40px;" type="text"/>		Apparatus Use <input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other		List up to 4 actions for each apparatus and each personnel. <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>	
--	--	---	--	---	--	---	--	---	--

Personnel ID ☆	Name	Rank or Grade	Attend <input checked="" type="checkbox"/>	Action Taken	Action Taken	Action Taken	Action Taken
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				

3 ID <input style="width: 40px;" type="text"/> ☆ Type <input style="width: 40px;" type="text"/>		Dispatch <input type="checkbox"/> <input style="width: 40px;" type="text"/> Arrival <input type="checkbox"/> <input style="width: 40px;" type="text"/> Clear <input type="checkbox"/> <input style="width: 40px;" type="text"/>		Sent <input type="checkbox"/> Number of People <input style="width: 40px;" type="text"/>		Apparatus Use <input type="checkbox"/> Suppression <input type="checkbox"/> EMS <input type="checkbox"/> Other		List up to 4 actions for each apparatus and each personnel. <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>	
--	--	---	--	---	--	---	--	---	--

Personnel ID ☆	Name	Rank or Grade	Attend <input checked="" type="checkbox"/>	Action Taken	Action Taken	Action Taken	Action Taken
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				
<input style="width: 40px;" type="text"/>			<input type="checkbox"/>				

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FIGURE 3-14. NFIRS-11 Arson Form

A FDID <input type="text"/> State <input type="text"/> Incident Date <input type="text"/> MM <input type="text"/> DD <input type="text"/> YYYY <input type="text"/> Station <input type="text"/> Incident Number <input type="text"/> Exposure <input type="text"/> <div style="float: right;"> <input type="checkbox"/> Delete <input type="checkbox"/> Change </div>		NFIRS-11 Arson	
B Agency Referred To <input type="checkbox"/> None			
<div style="display: flex; justify-content: space-between;"> <div> Number <input type="text"/> Prefix <input type="text"/> Street or Highway <input type="text"/> </div> <div> Agency Name <input type="text"/> Their case number <input type="text"/> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> Post Office Box <input type="text"/> Apt./Suite/Room <input type="text"/> City <input type="text"/> </div> <div> Street Type <input type="text"/> Suffix <input type="text"/> Their ORI <input type="text"/> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> State <input type="text"/> ZIP Code <input type="text"/> - <input type="text"/> Agency phone number <input type="text"/> </div> <div> Their Federal Identifier (FID) <input type="text"/> </div> </div>			
C Case Status 1 <input type="checkbox"/> Investigation open 2 <input type="checkbox"/> Investigation closed 3 <input type="checkbox"/> Investigation inactive 4 <input type="checkbox"/> Closed with arrest 5 <input type="checkbox"/> Closed with exceptional clearance		D Availability of Material First Ignited 1 <input type="checkbox"/> Transported to scene 2 <input type="checkbox"/> Available at scene U <input type="checkbox"/> Unknown	
E Suspected Motivation Factors Check up to three factors			
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> 11 <input type="checkbox"/> Extortion 12 <input type="checkbox"/> Labor unrest 13 <input type="checkbox"/> Insurance fraud 14 <input type="checkbox"/> Intimidation 15 <input type="checkbox"/> Void contract/lease 21 <input type="checkbox"/> Personal </div> <div style="width: 33%;"> 22 <input type="checkbox"/> Hate crime 23 <input type="checkbox"/> Institutional 24 <input type="checkbox"/> Societal 31 <input type="checkbox"/> Protest 32 <input type="checkbox"/> Civil unrest 41 <input type="checkbox"/> Fireplay/Curiosity </div> <div style="width: 33%;"> 42 <input type="checkbox"/> Vanity/Recognition 43 <input type="checkbox"/> Thrills 44 <input type="checkbox"/> Attention/Sympathy 45 <input type="checkbox"/> Sexual excitement 51 <input type="checkbox"/> Homicide 52 <input type="checkbox"/> Suicide 53 <input type="checkbox"/> Domestic violence </div> <div style="width: 33%;"> 54 <input type="checkbox"/> Burglary 61 <input type="checkbox"/> Homicide concealment 62 <input type="checkbox"/> Burglary concealment 63 <input type="checkbox"/> Auto theft concealment 64 <input type="checkbox"/> Destroy records/evidence 00 <input type="checkbox"/> Other suspected motivation UU <input type="checkbox"/> Unknown motivation </div> </div>			
F Apparent Group Involvement Check up to three factors <input type="checkbox"/> None 1 <input type="checkbox"/> Terrorist group 2 <input type="checkbox"/> Gang 3 <input type="checkbox"/> Anti-government group 4 <input type="checkbox"/> Outlaw motorcycle organization 5 <input type="checkbox"/> Organized crime 6 <input type="checkbox"/> Racial/Ethnic hate group 7 <input type="checkbox"/> Religious hate group 8 <input type="checkbox"/> Sexual preference hate group 0 <input type="checkbox"/> Other group U <input type="checkbox"/> Unknown		H Incendiary Devices Select one from each category	
G1 Entry Method <input type="text"/> Entry Method		CONTAINER <input type="checkbox"/> No container 11 <input type="checkbox"/> Bottle (glass) 14 <input type="checkbox"/> Pressurized container 17 <input type="checkbox"/> Box 12 <input type="checkbox"/> Bottle (plastic) 15 <input type="checkbox"/> Can (not gas or fuel) 00 <input type="checkbox"/> Other Container 13 <input type="checkbox"/> Jug 16 <input type="checkbox"/> Gasoline or fuel can UU <input type="checkbox"/> Unknown	
G2 Extent of Fire Involvement on Arrival <input type="text"/> Extent of Fire Involvement		IGNITION/DELAY DEVICE <input type="checkbox"/> No device 11 <input type="checkbox"/> Wick or fuse 17 <input type="checkbox"/> Road flare/fuse 12 <input type="checkbox"/> Candle 18 <input type="checkbox"/> Chemical component 13 <input type="checkbox"/> Cigarette and matchbook 19 <input type="checkbox"/> Trailer/Streamer 14 <input type="checkbox"/> Electronic component 20 <input type="checkbox"/> Open flame source 15 <input type="checkbox"/> Mechanical device 00 <input type="checkbox"/> Other delay device 16 <input type="checkbox"/> Remote control UU <input type="checkbox"/> Unknown	
I Other Investigative Information Check all that apply 1 <input type="checkbox"/> Code violations 2 <input type="checkbox"/> Structure for sale 3 <input type="checkbox"/> Structure vacant 4 <input type="checkbox"/> Other crimes involved 5 <input type="checkbox"/> Illicit drug activity 6 <input type="checkbox"/> Change in insurance 7 <input type="checkbox"/> Financial problem 8 <input type="checkbox"/> Criminal/Civil actions pending		J Property Ownership 1 <input type="checkbox"/> Private 2 <input type="checkbox"/> City, town, village, local 3 <input type="checkbox"/> County or parish 4 <input type="checkbox"/> State or province 5 <input type="checkbox"/> Federal 6 <input type="checkbox"/> Foreign 7 <input type="checkbox"/> Military 0 <input type="checkbox"/> Other	
K Initial Observations Check all that apply 1 <input type="checkbox"/> Windows ajar 5 <input type="checkbox"/> Fire department forced entry 2 <input type="checkbox"/> Doors ajar 6 <input type="checkbox"/> Entry forced prior to FD arrival 3 <input type="checkbox"/> Doors locked 7 <input type="checkbox"/> Security system activated 4 <input type="checkbox"/> Doors unlocked 8 <input type="checkbox"/> Security system present (not activated)		L Laboratory Used Check all that apply <input type="checkbox"/> None 1 <input type="checkbox"/> Local 3 <input type="checkbox"/> ATF 5 <input type="checkbox"/> Other 6 <input type="checkbox"/> Private 2 <input type="checkbox"/> State 4 <input type="checkbox"/> FBI Federal	

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FIGURE 3-15. NFIRS-11 Arson Form (side 2)

A FDID ☆ State ☆ Incident Date ☆ Station Incident Number ☆ Exposure ☆	<input type="checkbox"/> Delete <input type="checkbox"/> Change		NFIRS-11 Juvenile Firesetter
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<p>Complete this section if the person involved in the ignition of the fire was a child or Juvenile under the age of 18.</p>	M2 Age or Date of Birth <div style="margin-bottom: 10px;"> [] [] Age (in years) </div> <div style="text-align: center; margin-bottom: 10px;">OR</div> <div> [] [] [] [] Month Day Year </div>	M4 Race 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black, African American 3 <input type="checkbox"/> American Indian, Alaska Native 4 <input type="checkbox"/> Asian 5 <input type="checkbox"/> Native Hawaiian, Other Pacific Islander 0 <input type="checkbox"/> Other, multiracial U <input type="checkbox"/> Undetermined	M6 Family Type 1 <input type="checkbox"/> Single parent 2 <input type="checkbox"/> Foster parent(s) 3 <input type="checkbox"/> Two-parent family 4 <input type="checkbox"/> Extended family N <input type="checkbox"/> No family unit 0 <input type="checkbox"/> Other family type U <input type="checkbox"/> Unknown
M1 Subject Number <small>Complete a separate Section M form for each juvenile.</small> <div style="border: 1px solid black; width: 100px; height: 15px; margin: 0 auto;"></div> Subject Number	M3 Gender 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	M5 Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 0 <input type="checkbox"/> Non Hispanic or Latino	

M7 Motivation/Risk Factors <small>Check only one of codes 1–3 and then all others (4–9) that apply.</small> 1 <input type="checkbox"/> Mild curiosity about fire 2 <input type="checkbox"/> Moderate curiosity about fire 3 <input type="checkbox"/> Extreme curiosity about fire <hr/> 4 <input type="checkbox"/> Diagnosed (or suspected) ADD/ADHD 5 <input type="checkbox"/> History of trouble outside school 6 <input type="checkbox"/> History of stealing or shoplifting 7 <input type="checkbox"/> History of physically assaulting others 8 <input type="checkbox"/> History of fireplay or firesetting 9 <input type="checkbox"/> Transiency 0 <input type="checkbox"/> Other U <input type="checkbox"/> Unknown	M8 Disposition of Person Under 18 1 <input type="checkbox"/> Handled within department 2 <input type="checkbox"/> Released to parent/guardian 3 <input type="checkbox"/> Referred to other authority 4 <input type="checkbox"/> Referred to treatment/counseling program 5 <input type="checkbox"/> Arrested, charged as adult 6 <input type="checkbox"/> Referred to firesetter intervention program 0 <input type="checkbox"/> Other U <input type="checkbox"/> Unknown
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N Remarks (local use)	
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FIGURE 3-16. NFIRS 1S - Supplemental Form

A	FDID <input type="text"/>	State <input type="text"/>	Incident Date <input type="text"/>	Station <input type="text"/>	Incident Number <input type="text"/>	Exposure <input type="text"/>	<input type="checkbox"/> Delete <input type="checkbox"/> Change	NFIRS-1S Supplemental
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K1 Person/Entity Involved

Local Option ☐ Check this box if same address as incident location. Then skip these three duplicate address lines.

Business Name (if applicable)

Area Code Phone Number

Mr., Ms., Mrs. First Name MI Last Name Suffix

Number Prefix Street or Highway Street Type Suffix

Post Office Box Apt./Suite/Room City

State ZIP Code

K1 Person/Entity Involved

Local Option ☐ Check this box if same address as incident location. Then skip these three duplicate address lines.

Business Name (if applicable)

Area Code Phone Number

Mr., Ms., Mrs. First Name MI Last Name Suffix

Number Prefix Street or Highway Street Type Suffix

Post Office Box Apt./Suite/Room City

State ZIP Code

K1 Person/Entity Involved

Local Option ☐ Check this box if same address as incident location. Then skip these three duplicate address lines.

Business Name (if applicable)

Area Code Phone Number

Mr., Ms., Mrs. First Name MI Last Name Suffix

Number Prefix Street or Highway Street Type Suffix

Post Office Box Apt./Suite/Room City

State ZIP Code

K1 Person/Entity Involved

Local Option ☐ Check this box if same address as incident location. Then skip these three duplicate address lines.

Business Name (if applicable)

Area Code Phone Number

Mr., Ms., Mrs. First Name MI Last Name Suffix

Number Prefix Street or Highway Street Type Suffix

Post Office Box Apt./Suite/Room City

State ZIP Code

K1 Person/Entity Involved

Local Option ☐ Check this box if same address as incident location. Then skip these three duplicate address lines.

Business Name (if applicable)

Area Code Phone Number

Mr., Ms., Mrs. First Name MI Last Name Suffix

Number Prefix Street or Highway Street Type Suffix

Post Office Box Apt./Suite/Room City

State ZIP Code

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FIGURE 3-17. NFIRS 1S - Supplemental Form (side 2)

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