

# Leach VFD Incident Report

DATE / /	ALARM TIME :	ARRIVAL TIME :	CONTROL TIME :	LAST UNIT CLEARED :	INCIDENT #	EXPOSURE #
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<b>LOCATION</b> <input type="checkbox"/> Exact Location <input type="checkbox"/> Intersection <input type="checkbox"/> Front of <input type="checkbox"/> Rear of <input type="checkbox"/> Adjacent to	_____ Number	_____ Street or Highway	_____ Apt/Room	_____ City	_____ State	_____ Zip Code
_____ Cross Streets or Directions						

<b>INCIDENT TYPE</b> <input type="checkbox"/> Structure Fire <input type="checkbox"/> Brush Fire <input type="checkbox"/> MVA <input type="checkbox"/> Medical Call <input type="checkbox"/> Other Aid Given <input type="checkbox"/> Other: _____	<b>AID GIVEN OR RECEIVED</b> <input type="checkbox"/> Mutual Aid Received <input type="checkbox"/> Automatic Aid Received <input type="checkbox"/> Mutual Aid Given <input type="checkbox"/> Automatic Aid Given <input type="checkbox"/> Other Aid Given <input type="checkbox"/> None	<b>AID GIVEN OR RECEIVED FROM/TO:</b> <input type="checkbox"/> Oaks VFD <input type="checkbox"/> Kenwood VFD <input type="checkbox"/> Kansas VFD <input type="checkbox"/> Chimney Rock VFD <input type="checkbox"/> Lowery VFD <input type="checkbox"/> Other _____	<b>RESOURCES</b> <table style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">Apparatus</td> <td style="width: 50%; text-align: center;">Personnel</td> </tr> <tr> <td style="text-align: center;">Suppression</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">EMS</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">Other</td> <td style="text-align: center;">_____</td> </tr> </table>	Apparatus	Personnel	Suppression	_____	EMS	_____	Other	_____
Apparatus	Personnel										
Suppression	_____										
EMS	_____										
Other	_____										

<b>ESTIMATED DOLLAR LOSS LOSSES</b> Property \$ _____ Contents \$ _____ <b>PRE-INCIDENT VALUE</b> Property \$ _____ Contents \$ _____	<b>CASUALTIES</b> <table style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">Death</td> <td style="width: 50%; text-align: center;">Injury</td> </tr> <tr> <td style="text-align: center;">Fire Service</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">Civilian Fire</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">Civilian EMS</td> <td style="text-align: center;">_____</td> </tr> </table>	Death	Injury	Fire Service	_____	Civilian Fire	_____	Civilian EMS	_____	<b>DETECTORS</b> (Required for Confined Fires Only) <input type="checkbox"/> Detector Alerted Occupants <input type="checkbox"/> Detector Did Not Alert Occupants <input type="checkbox"/> Unknown	<b>ACTIONS TAKEN</b> _____ Primary Action Taken _____ Additional Action Taken (1) _____ Additional Action Taken (2) _____
Death	Injury										
Fire Service	_____										
Civilian Fire	_____										
Civilian EMS	_____										

<b>HAZARDOUS MATERIALS RELEASE</b> <input type="checkbox"/> NONE <input type="checkbox"/> NATURAL GAS : slow leak, no evacuation or HazMat action <input type="checkbox"/> PROPANE GAS: <21 LB. (as in home BBQ grill) <input type="checkbox"/> GASOLINE: vehicle fuel tank or portable container <input type="checkbox"/> KEROSENE: fuel burning equipment or portable storage <input type="checkbox"/> DIESEL FUEL/FUEL OIL: vehicle tank or portable storage <input type="checkbox"/> HOUSEHOLD SOLVENTS: home/office spill, cleanup only <input type="checkbox"/> MOTOR OIL: from engine or portable container <input type="checkbox"/> PAINT: from paints cans totaling <55 gallons <input type="checkbox"/> OTHER: Special HazMat actions required or spill > 55 gallons	<b>MIXED USE PROPERTY</b> <table style="width: 100%;"> <tr> <td style="width: 50%;"> <input type="checkbox"/> Not Mixed  <input type="checkbox"/> Assembly Use  <input type="checkbox"/> Educational Use  <input type="checkbox"/> Medical Use  <input type="checkbox"/> Residential Use  <input type="checkbox"/> Row of Stores  <input type="checkbox"/> Enclosed Mall  <input type="checkbox"/> Business &amp; Residential  <input type="checkbox"/> Office Use           </td> <td style="width: 50%;"> <input type="checkbox"/> Industrial Use  <input type="checkbox"/> Military Use  <input type="checkbox"/> Farm Use  <input type="checkbox"/> Other Mixed Use           </td> </tr> </table>	<input type="checkbox"/> Not Mixed <input type="checkbox"/> Assembly Use <input type="checkbox"/> Educational Use <input type="checkbox"/> Medical Use <input type="checkbox"/> Residential Use <input type="checkbox"/> Row of Stores <input type="checkbox"/> Enclosed Mall <input type="checkbox"/> Business & Residential <input type="checkbox"/> Office Use	<input type="checkbox"/> Industrial Use <input type="checkbox"/> Military Use <input type="checkbox"/> Farm Use <input type="checkbox"/> Other Mixed Use
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OCCUPANT/PARTY INVOLVED NAME (LAST, FIRST, MIDDLE)	ADDRESS/CITY/ZIP CODE	TELEPHONE
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OWNER NAME (LAST, FIRST, MIDDLE)	ADDRESS/CITY/ZIP CODE	ROOM / APT #	TELEPHONE
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<b>NOTES:</b> _____ _____ _____ _____ _____ _____	<b>PERSONNEL ON SCENE</b> <table style="width: 100%;"> <tr> <td style="width: 50%;"> <input type="checkbox"/> Leach #1  <input type="checkbox"/> Leach #2  <input type="checkbox"/> Leach #3  <input type="checkbox"/> Leach #4  <input type="checkbox"/> Leach #5  <input type="checkbox"/> Leach #6  <input type="checkbox"/> Leach #7  <input type="checkbox"/> Leach #8  <input type="checkbox"/> Leach #9           </td> <td style="width: 50%;"> <input type="checkbox"/> Leach #10  <input type="checkbox"/> Leach #11  <input type="checkbox"/> Leach #12  <input type="checkbox"/> Leach #13  <input type="checkbox"/> Leach #14  <input type="checkbox"/> Leach #15  <input type="checkbox"/> Leach #16  <input type="checkbox"/> Leach #17  <input type="checkbox"/> Leach #18           </td> </tr> </table> # From Other Depts: _____	<input type="checkbox"/> Leach #1 <input type="checkbox"/> Leach #2 <input type="checkbox"/> Leach #3 <input type="checkbox"/> Leach #4 <input type="checkbox"/> Leach #5 <input type="checkbox"/> Leach #6 <input type="checkbox"/> Leach #7 <input type="checkbox"/> Leach #8 <input type="checkbox"/> Leach #9	<input type="checkbox"/> Leach #10 <input type="checkbox"/> Leach #11 <input type="checkbox"/> Leach #12 <input type="checkbox"/> Leach #13 <input type="checkbox"/> Leach #14 <input type="checkbox"/> Leach #15 <input type="checkbox"/> Leach #16 <input type="checkbox"/> Leach #17 <input type="checkbox"/> Leach #18	<b>EQUIPMENT ON SCENE</b> <input type="checkbox"/> Engine #1 <input type="checkbox"/> Tanker #1 <input type="checkbox"/> Quick Attack #1 <input type="checkbox"/> Brush #1 <input type="checkbox"/> Brush #2 <input type="checkbox"/> Brush #3 <input type="checkbox"/> Other <input type="checkbox"/> Other
<input type="checkbox"/> Leach #1 <input type="checkbox"/> Leach #2 <input type="checkbox"/> Leach #3 <input type="checkbox"/> Leach #4 <input type="checkbox"/> Leach #5 <input type="checkbox"/> Leach #6 <input type="checkbox"/> Leach #7 <input type="checkbox"/> Leach #8 <input type="checkbox"/> Leach #9	<input type="checkbox"/> Leach #10 <input type="checkbox"/> Leach #11 <input type="checkbox"/> Leach #12 <input type="checkbox"/> Leach #13 <input type="checkbox"/> Leach #14 <input type="checkbox"/> Leach #15 <input type="checkbox"/> Leach #16 <input type="checkbox"/> Leach #17 <input type="checkbox"/> Leach #18			

<b>AUTHORIZATION</b> _____ Officer in Charge _____ Member Making Report	<b>ADD'L NOTES:</b> _____ _____ _____
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<b>Property Details</b> <input type="checkbox"/> Not Residential Estimated # of residential living units in the building of origin whether or not all units became involved _____ <input type="checkbox"/> Buildings not involved Number of buildings involved _____ <input type="checkbox"/> None Acres burned (outside fires) _____ <input type="checkbox"/> Less than 1 acre	<b>On-Site Materials</b> <input type="checkbox"/> None <input checked="" type="checkbox"/> Bulk storage or warehousing <input checked="" type="checkbox"/> Processing or manufacturing <input checked="" type="checkbox"/> Packaged goods for sale <input checked="" type="checkbox"/> Repairs or service On-Site Material (1) _____ <input checked="" type="checkbox"/> Bulk storage or warehousing <input checked="" type="checkbox"/> Processing or manufacturing <input checked="" type="checkbox"/> Packaged goods for sale <input checked="" type="checkbox"/> Repairs or service On-Site Material (2) _____ <input checked="" type="checkbox"/> Bulk storage or warehousing <input checked="" type="checkbox"/> Processing or manufacturing <input checked="" type="checkbox"/> Packaged goods for sale <input checked="" type="checkbox"/> Repairs or service On-Site Material (3) _____	<b>Ignition</b> Area of Fire Origin _____ Heat Source _____ Item First Ignited _____ <input type="checkbox"/> Fire spread confined to object of origin Type of Material First Ignited _____	<b>Cause of Ignition</b> <input checked="" type="checkbox"/> Intentional <input checked="" type="checkbox"/> Unintentional <input checked="" type="checkbox"/> Failure of Equipment or Heat Source <input checked="" type="checkbox"/> Act of Nature <input checked="" type="checkbox"/> Cause Under Investigation <input checked="" type="checkbox"/> Cause Undetermined after Investigation <b>Factors Contributing to Ignition</b> <input type="checkbox"/> None Factor #1 _____ Factor #2 _____
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<b>Human Factors Contributing to Ignition</b> <input type="checkbox"/> None <input type="checkbox"/> Asleep <input type="checkbox"/> Possibly impaired by alcohol/drugs <input type="checkbox"/> Unattended person <input type="checkbox"/> Possibly mentally disabled <input type="checkbox"/> Physically disabled <input type="checkbox"/> Multiple persons involved <input type="checkbox"/> Age was a factor	<b>Equipment Involved in Ignition</b> <input type="checkbox"/> None Equipment Involved _____ Brand _____ Model _____ Serial Number _____ <input type="checkbox"/> Portable <input type="checkbox"/> Stationary Year _____ Equipment Power Source _____	<b>Mobile Property Involved</b> <input type="checkbox"/> None <input type="checkbox"/> Not involved in ignition, but burned <input type="checkbox"/> Involved in ignition, but didn't burn <input type="checkbox"/> Involved in ignition and burned Mobile Property Type _____ Mobile Property Make _____ Year _____ Mobile Property Model _____ VIN Number _____ License Plate Number _____ State _____
<b>Fire Suppression Factors</b> Fire Suppression Factor (1) _____ Fire Suppression Factor (2) _____ Fire Suppression Factor (3) _____		

<b>Structure Type</b> <input type="checkbox"/> Enclosed building <input type="checkbox"/> Fixed portable/mobile structure <input type="checkbox"/> Open structure <input type="checkbox"/> Air supported structure <input type="checkbox"/> Tent <input type="checkbox"/> Open platform (e.g. piers) <input type="checkbox"/> Underground structure (work areas) <input type="checkbox"/> Connective structure (e.g. fences) <input type="checkbox"/> Other type of structure	<b>Building Status</b> <input type="checkbox"/> Under construction <input type="checkbox"/> Occupied & operating <input type="checkbox"/> Idle, not routinely used <input type="checkbox"/> Under major renovation <input type="checkbox"/> Vacant & secured <input type="checkbox"/> Vacant & unsecured <input type="checkbox"/> Being demolished <input type="checkbox"/> Undetermined <input type="checkbox"/> Other	<b>Building Height</b> (Count ROOF as part of Highest Story) Total # of stories at or above grade _____ Total # of stories below grade _____ Main Floor Size (Complete One) Total square feet _____ Length in Feet _____ BY _____ Width in Feet _____	<b>Fire Origin</b> _____ <input type="checkbox"/> Below Grade Story of origin _____ <b>Fire Spread</b> <input type="checkbox"/> Confined to object of origin <input type="checkbox"/> Confined to room of origin <input type="checkbox"/> Confined to floor of origin <input type="checkbox"/> Confined to building of origin <input type="checkbox"/> Beyond building of origin
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<b>Number of Stories Damaged by Flame</b> _____ Number of stories w/ minor damage (1 to 24% Flame Damage) _____ Number of stories w/ significant damage (25 to 49% Flame Damage) _____ Number of stories w/ heavy damage (50 to 74% Flame Damage) _____ Number of stories w/ extreme damage (75 to 100% Flame Damage)	<b>Material Contributing Most to Flame Spread</b> _____ Item contributing most to flame spread _____ Type of material contributing most to flame spread	<b>Insurance Company Information</b> Insurance Company Name _____ Policy Number _____ Agent's Name _____ Phone Number _____
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<b>Presence of Detectors</b> <input type="checkbox"/> None Present <input type="checkbox"/> Present Detector Power Supply _____ <b>Detector Type</b> <input type="checkbox"/> Smoke <input type="checkbox"/> Heat <input type="checkbox"/> Combination-smoke & heat <input type="checkbox"/> Sprinkler, water flow detection <input type="checkbox"/> More than 1 type present <b>Detector Operation</b> <input type="checkbox"/> Fire too small to activate <input type="checkbox"/> Operated <input type="checkbox"/> Failed to Operate <input type="checkbox"/> Undetermined	<b>Detector Effectiveness</b> <input type="checkbox"/> Alerted occupants-they responded <input type="checkbox"/> Occupants failed to respond <input type="checkbox"/> There were no occupants <input type="checkbox"/> Failed to alert occupants <b>Detector Failure Reason</b> _____	<b>Presence of Automatic Extinguishing System</b> <input type="checkbox"/> None Present <input type="checkbox"/> Present Type of System _____ # of Heads Operating _____ <b>System Operation</b> <input type="checkbox"/> Operated & effective <input type="checkbox"/> Operated & not effective <input type="checkbox"/> Fire too small to activate <input type="checkbox"/> Failed to operate <input type="checkbox"/> Other <b>System Failure Reason</b> _____
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