



# Delaware State Fire Commission

## FireFighter Injury Report



### INCIDENT

Organization/Fire Department	Date of Report	Time of Report
Report Number	Date of Incident	Time of Incident
Date of Incident	Incident Location	
Incident Commander		

### INCIDENT ACTIVITIES

Property Type	MAYDAY Activated	Yes	No
RIT Activated	RIT	Yes	No
Injury Occurred During	Type of Incident		

### INJURED PERSON

Last Name	First Name	Middle
Address		
Organization/Fire Dept Affiliated		
Phone	Email	
Sex	Age Group	
Type of Service	Years of Experience	Severity
Injury Location	Activity when Injured	
Primary Symptom	Primary Body Part	Injury Factor
Transported	Facility	
Yes		
No		

### PERSONAL PROTECTIVE EQUIPMENT

Department issued equipment worn properly and within NFPA guidelines? Yes  No

If no, please indicate why:

Did the protective equipment fail and or contribute to the injury? Yes  No  If yes, please complete the below:

Protective Equipment Item

Head or Face Protection	Coat, Shirt or Trousers	Boots or Shoes
Hand Protection	Respiratory Protection	

Please list all failed equipment manufacturer, model, and serial numbers.

In your opinion, how can future incidents be prevented?

PPE  Training  Policy/Procedure  None  Other

### WITNESS

Last Name	First Name	Last Name	First Name
Address		Address	
Organization/Fire Dept Affiliated		Organization/Fire Dept Affiliated	
Phone		Phone	
Email		Email	



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**INCIDENT NARRATIVE OF INJURY**

Empty space for the incident narrative of injury.

**FIRE DEPARTMENT COMMENTS and/or RECOMMENDATIONS**

Empty space for fire department comments and/or recommendations.

**[CLICK TO EMAIL](#)**



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**FIRE COMMISSION COMMENTS and/or RECOMMENDATIONS**

A large, empty rectangular box with a red border, intended for entering fire commission comments and/or recommendations.