

New Jersey Division of Fire Safety
Office of the State Fire Marshal
Fire Fatality Report Form

Rec'd by: _____
Date Rec'd: _____
Time Rec'd: _____

Date of Incident:	Alarm Time (24 Hr):	Municipality:
Incident Address:		Zip:
Fire Department Name:		FDID:

Please check this box if property was an Illegal Residential Conversion → <input type="checkbox"/>	NFIRS Participant: (Check One)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Name:	Age:	Gender:	Affiliation: (Check One)	<input type="checkbox"/> Civilian <input type="checkbox"/> Firefighter <input type="checkbox"/> Other Emergency Personnel
Name:	Age:	Gender:	Affiliation: (Check One)	<input type="checkbox"/> Civilian <input type="checkbox"/> Firefighter <input type="checkbox"/> Other Emergency Personnel
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Cause of Fire:	Type of Occupancy:
	Room of Origin:
Detector Present: <input type="checkbox"/> Yes <input type="checkbox"/> No (Check One)	Detector Operate: <input type="checkbox"/> Yes <input type="checkbox"/> No (Check One)

Reporting Agency:	Name: (Person Completing Form)	Phone:
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Remarks: