DEPARTMENT OF DEVELOPMENTAL SERVICES
OFFICE OF QUALITY MANAGEMENT, QUALITY ENHANCEMENT DIVISION
E. FIRE DRILL REPORT

Date: ____________________ Time: ______________ AM _____ PM _____

Provider: ____

Address of Home: ____
include Apt/Unit # if applicable

Name of staff on duty: ______________________ Staff # Asleep: ______ Staff # Awake: ______

Capacity of the Home: _____ Individuals not present at time of drill: ______________________

Individuals not asleep at time of drill: ______________________

Exit blocked? ________ Which one(s): ______________________

Individual's Name (Initials Only)	Evacuation Time	Type of Assistance (independent, verbal, gestural, tactile, physical)	Location of Bedroom	Non-Ambulatory	Adaptive Device(s)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Comments:

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______________________ ______________________
Staff Signature QE Specialist Signature

cc: Provider File