

NHICS FORM 259 | MASTER FACILITY CASUALTY/FATALITY REPORT

1. INCIDENT NAME:					
2. FACILITY NAME:					
3. DATE/TIME PREPARED:	4. OPERATIONAL PERIOD DATE/TIME:				
5. REPORTED CASUALTY/FATALITY					
	RESIDENT NAME:			MEDICAL RECORD #:	
INJURY		TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME	
	RESIDENT NAME:			MEDICAL RECORD #:	
INJURY		TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME	
	RESIDENT NAME:			MEDICAL RECORD #:	
INJURY		TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME	
	RESIDENT NAME:			MEDICAL RECORD #:	
INJURY		TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME	
	RESIDENT NAME:			MEDICAL RECORD #:	
INJURY		TRANSFER DATE / TIME	RECEIVING HOSPITAL	EXPIRED DATE / TIME	
6. PREPARED BY OPERATIONS SECTION:					