



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 DIVISION OF REGULATION AND LICENSURE
 SECTION FOR LONG-TERM CARE REGULATION

FACILITY ID NUMBER

ANNUAL FIRE DEPARTMENT CONSULTATION

**SNF/ICF – 19 CSR 30-85.022(33) and RCF/ALF – 19 CSR 30-86.022(5)(A)
 ALL FACILITIES SHALL REQUEST CONSULTATION AND ASSISTANCE ANNUALLY FROM A LOCAL FIRE UNIT.**

FACILITY NAME		FACILITY TYPE	
		<input type="checkbox"/> RCF <input type="checkbox"/> ALF <input type="checkbox"/> ICF <input type="checkbox"/> SNF	
ADDRESS (STREET, CITY, ZIP CODE)			
OWNER		ADMINISTRATOR/MANAGER	

This is to certify that I, the undersigned, have consulted with the Administrator/Manager of the above-named facility and find that this facility is in compliance with all city/county fire prevention codes, and the items indicated below were discussed.

	YES	NO
1. Was assistance given with an actual fire evacuation drill?	<input type="checkbox"/>	<input type="checkbox"/>
2. Was assistance given with fire safety training?	<input type="checkbox"/>	<input type="checkbox"/>
3. Was fire evacuation planning discussed and facility plans reviewed?	<input type="checkbox"/>	<input type="checkbox"/>
4. Was fire protection equipment inspected for maintenance and operation?	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS

FIRE DEPARTMENT REPRESENTATIVE SIGNATURE	PRINT NAME AND TITLE	TELEPHONE NUMBER
ADDRESS (STREET, CITY, ZIP CODE)	DATE COMPLETED	

RETURN TO: **MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
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 REGION**

ADDRESS

CITY, STATE, ZIP CODE