

# LIFE SAFETY CODE FACILITY DEMOGRAPHIC FORM

(Please Print or Type – Complete in its entirety)

FACILITY INFORMATION				
Today's date:		CCN#:		
Name of Facility:				
Person Completing Form:				
Street address:		City:	State:	Zip:
Type of Provider:	<input type="checkbox"/> LTC <input type="checkbox"/> Hospital <input type="checkbox"/> ASC <input type="checkbox"/> Birthing Center <input type="checkbox"/> ESRD <input type="checkbox"/> Other:			

LOCAL FIRE SERVICE INFORMATION				
Local Fire Department:		Contact Person:		Phone:
Street address:		City:	State:	Zip:

FACILITY CONSTRUCTION & PHYSICAL PROPERTIES				
Construction Type:		Refer to NFPA ( <b>Not IBC</b> ) 101- Ch.18/19.1.6 or 20/21.1.6 for construction type <b>or</b> facility blueprints		
Date of Plan Approval:		Number of Smoke Compartments:		
Date of Construction:		Fire separation between occupancies?	<input type="checkbox"/> 1 h <input type="checkbox"/> 2 h <input type="checkbox"/> 3 h <input type="checkbox"/> None	
Date Originally Occupied:		Trash/Laundry Chutes or Incinerators?		
Number of Beds:		Number of Stories:		
Please list any <b>MAJOR</b> remodel, rehab, construction, additions, repair and/or change of occupancy (Refer to NFPA 101: 18.1 or 19.1):				
Type: <input type="checkbox"/> Remodel <input type="checkbox"/> Rehab <input type="checkbox"/> Repair <input type="checkbox"/> Renovation <input type="checkbox"/> Additions (wings or building) <input type="checkbox"/> Reconstruction <input type="checkbox"/> Change of Occupancy				
Year:	Location:	Reason:		
Type: <input type="checkbox"/> Remodel <input type="checkbox"/> Rehab <input type="checkbox"/> Repair <input type="checkbox"/> Renovation <input type="checkbox"/> Additions (wings or building) <input type="checkbox"/> Reconstruction <input type="checkbox"/> Change of Occupancy				
Year:	Location:	Reason:		
<b><i>If more space is need, please use another piece of paper and attached with this form</i></b>				

GENERATOR / ELECTRICAL INFORMATION				
Does the facility use any life support type machines?				
<i>Please refer to NFPA 99: 6.4.4, 6.5.4 and 6.6.4 to fill out Category Type</i>				
Generator #1 Make and Model:	Year Manufactured :	NFPA 99 Category Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
Generator #2 Make and Model:	Year Manufactured :	NFPA 99 Category Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
Generator #3 Make and Model:	Year Manufactured :	NFPA 99 Category Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
Has an assessment of Essential Electric System Categories in accordance with NFPA 99: 6.3.2.2.10 been completed ?				<input type="checkbox"/> Y <input type="checkbox"/> N
Has an assessment of portable patient-care related electrical equipment for testing intervals been completed? NFPA 99 10.5.2.1				<input type="checkbox"/> Y <input type="checkbox"/> N

MEDICAL GAS AND VACUUM INFORMATION				
Does the facility use piped medical gas?		Oxygen Generator on-site?		
Does the facility trans fill their own tanks?		Storage of >20,000 ft <sup>3</sup> of medical gas?		
Category Type of Gas & Vacuum System?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A   ← Use NFPA 99 Chapter 4 & 5 to fill out Category Type			
Does the facility have educational in-services and/or training for employees who handle, transport, trans-fill medical gas?				<input type="checkbox"/> Y <input type="checkbox"/> N

### FIRE ALARM INFORMATION

Make & Model:		Year Manufactured:		Year Installed:	
List all device types under the fire alarm system: <input type="checkbox"/> Smoke Detector <input type="checkbox"/> Heat Detector <input type="checkbox"/> Dampers <input type="checkbox"/> Other:					
Does the facility use an engineer smoked control system? If so where?					
Date of prior smoke/fire damper fusible link replacement/testing:					

### SPRINKLER SYSTEM INFORMATION

Make & Model:		Year Installed:	
List all device types und sprinkler system:	<input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Quick Response Heads <input type="checkbox"/> Standard Response Heads <input type="checkbox"/> Other:		
Source of water for suppression system:	<input type="checkbox"/> Domestic <input type="checkbox"/> Water Tanks <input type="checkbox"/> Body of Water <input type="checkbox"/> Other:		
Date of last obstruction testing (wet AND dry):			

### EMERGENCY PLAN INFORMATION

Has a vulnerability assessment been completed, reviewed and implemented into an emergency plan?	
Has an emergency plan been developed, reviewed, revised and updated accordingly?	

### FACILITY FLOOR PLAN – BE SURVEY READY

Facility map showing all the follow per floor:

- |  |  |
|--|--|
| <input type="checkbox"/> Smoke Compartment Division & Sizes (ft <sup>2</sup> )<br><input type="checkbox"/> Exit Locations/Exit Egress/Identified Corridor Space<br><input type="checkbox"/> Fire Barrier/Separations<br><input type="checkbox"/> Smoke Barrier/Separations<br><input type="checkbox"/> Legend that clearly identifies required information<br><input type="checkbox"/> Location of Fire Extinguishers, Pull Alarms, Fire Alarm Panels (optional but recommended) | <input type="checkbox"/> All Resident/Patient Room Sizes (ft <sup>2</sup> )<br><input type="checkbox"/> Identified Hazardous Rooms & Sizes (ft <sup>2</sup> )<br><input type="checkbox"/> Suite Sizes(ft <sup>2</sup> )<br><input type="checkbox"/> Labeled Rooms and Areas<br><input type="checkbox"/> Location of chutes and vertical shafts |
|--|--|

**Please provide a completed copy of the facility floor plan to the Life Safety Code Inspector via E-Mail. This allows the inspector to have a copy on hand if the facility needs regulatory guidance regarding the Life Safety Code outside of the standard LSC survey.**