

**NHICS FORM 259 | MASTER FACILITY CASUALTY/FATALITY REPORT**

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