Circle Of Support, Inc.

Fire Drill Report

COMPLETE ONCE A MONTH

Address: _____ Date of Drill: _____

Time of Drill: _____AM/PM Time Used: _____Exit(s) Used: _____

PARTICIPANTS:

1._____ 2. _____3. _____

Designated Spot: _____

Comments: (i.e. any problems encountered with consumers, weather conditions, etc.)

_____

_____

Note*: If drills exceed 4 minutes immediately contact QIDP; conduct more drills to have the time less than 4 minutes.*

_____ _____

Staff Name/Signature **Title**

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HOME SAFETY CHECKLIST

COMPLETE ONCE A MONTH OR AS NEEDED

DATE: _____ TIME: ADDRESS: _____

Check the following areas if safe and clean, and if appropriate to the needs of the individuals living in the home:

Home Safety	Yes	No	If "No," describe problem noted
Living Room			
Kitchen/ Appliances			
Bedroom			
Bathroom			
Hallway			
Stairways			
First Aid Kit			
Carbon Monoxide Detector			
Fire Extinguisher (exp. date)			
Smoke Detector			
Electrical/Heating/Plumbing			
Waste/Garbage			

_____ _____

Staff Name/Signature **Title**