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This form may be submitted electronically by clicking the "Submit by Email" button when completed, or it may be printed and submitted by mail or fax. Thank you for participating in this voluntary reporting program.

MINNESOTA DEPARTMENT OF PUBLIC SAFETY

Fireworks Injury Report

Name of Medical Facility:

Facility Address:

City: MN ZIP Code:

Date of Injury: Age of Victim: Gender:

Description of Injury:

Type of Fireworks Involved: If Other,Describe:

Comments:

Optional *- For use in case additional information is necessary. Name and phone number will not become part of the injury database.*

Name of Person Completing Report: Day Phone:

Enter numbers only - no other characters.

To submit by mail or fax:

MN State Fire Marshal Division
Fireworks Injury Reporting Program
444 Cedar Street, Suite 145
St. Paul, MN 55101-5145

Fax: (651) 215-0541