Washington Military Department
Emergency Management Division

FUEL, TOLL & FERRY REIMBURSABLE EXPENSES CLAIM FORM EMD-036

(See WAC 118-04-360 for detailed instructions)

CLAIMANT'S INSTRUCTIONS

1. This form is in two (2) parts: **Part One i**s required general information and eligible reimbursable fuel, ferry crossing, and toll bridge expenses. **Part Two** is to be completed by the local Director of Emergency Management.
2. All responses **must be in ink** and all requested items **must be completed**. **DO NOT PRINT TWO-SIDED.**
3. Claimant **must be a registered Emergency Worker or eligible organization** in accordance with Revised Code of Washington (RCW) 38.52, and Washington Administrative Code (WAC) 118-04, and must have been mobilized by and working under Emergency Management authority at the time the expense was incurred.
4. A **State Mission or Evidence Search Mission number** must have been assigned.
5. **Receipts** for all claimed expenses **must be included**. Fasten receipts smaller than 8.5 x 11 inches to letter-size paper.
6. For fuel reimbursement, start mission with full tank and refuel as needed, but not later than 24 hours following return from mission. Only fuel used on the mission including travel to and from is reimbursable.
7. When completed, **this form must be signed on page two** by the claimant or claimant's representative.
8. **Claimant must be registered as a Payee (Vendor)** with the Department of Enterprise Services, Statewide Payee Desk (see: **http://www.des.wa.gov/services/ContractingPurchasing/Business/VendorPay/Pages/default.aspx).** **Enter Statewide Vendor Number (SVN) below.**
9. If claimant is unable to present and file the claim (due to incapacitation, etc.) or if claimant is a minor, or a nonresident of the state, the claim may be presented and filed on behalf of the claimant by claimant's legal representative, any relative, attorney, or agency representing the claimant.
10. **Submit original claim and all supporting documentation to your local Director of Emergency Management or Search and Rescue Coordinator (WAC 118-04-360).**

PART ONE

To Be Completed by Emergency Worker (Claimant) or Representative

Claimant's Name			Emergency Worker Card #	
Address			County Registered	
City	State		Zip Code	Telephone - Home
Statewide Vendor/Payee Number (SVN)	Email			Telephone - Cell
Vehicle Description Make	Type (Car, PU, 4x4, Van)		Year	License # / State

MISSION INFORMATION

State Mission #	Date of Incident	County Where Mission Occurred		**FUEL** (Start Mission with Full Tank)		Total Costs **$**
Was Mission Participation Over 24 Hours?	YES	NO		Total Gallons Purchased During Mission		
Was Vehicle Driven More Than 100 Miles?	YES	NO				
Departed Home	Date	Time		**BRIDGE / FERRY RECEIPTS** Multiple crossings on a mission for a vehicle must be added together.		Total Costs **$**
Returned Home	Date	Time				

LIST ALL PASSENGERS BELOW

Name	Emergency Worker #	Name	Emergency Worker #
Name	Emergency Worker #	Name	Emergency Worker #

Attach Receipts to This Form and Submit to Your Local DEM Office for Processing

TOTAL AMOUNT OF CLAIM $

Emergency Worker (Claimant) or Legal Representative MUST Sign This Claim Form

I hereby certify or "declare" under penalty of perjury under the laws of the State of Washington that the foregoing is a true and correct claim for necessary expenses incurred by me or claimant and that no payment has been received by me or claimant on account thereof.

SIGNATURE OF EMERGENCY WORKER OR RGANIZATION REPRESENTATIVE (CLAIMANT) DATE

Address City State Zip Code

If the Claimant is incapacitated from verifying, presenting, and filing the claim or if the claimant is a minor, or is a nonresident of the state, the claim may be verified, presented, and filed on behalf of the claimant by any relative, attorney, or agent representing the claimant.

(Note: For general statutory provisions governing claims against the State of Washington, see chapter 4.92.100 RCW. For specific information regarding Emergency Management Worker Claims, see chapter 38.52 RCW)

PART TWO

To Be Completed by The Emergency Management / Services Director or Designee for the Jurisdiction Where the Claimant Is Registered or for the Jurisdiction Where the Incident Occurred

I have reviewed the information in Part One and it is true to my best knowledge and belief.

DIRECTOR'S SIGNATURE DATE

PRINT NAME

If total claim for mission/incident number exceeds $2,000.00, before sending in the claim, a compensation board must review the claim in accordance with RCW 38.52.210. Contact Washington Emergency Management Division for further information.

Mail completed form with all documentation to:

State SAR Coordinator
Emergency Management Division
Washington Military Department
20 Aviation Drive
Camp Murray, WA 98430-5122

[ ] Don't Forget to Check:
[ ] Copy of EMD-078 with Emergency Worker name showing?
[ ] Receipts as specified included?
[ ] Form(s) properly filled out and signed?