

STATE OF WASHINGTON EMERGENCY WORKER DAILY ACTIVITY REPORT

County In Which Mission Took Place: _____ State Mission Number: _____

Mission Name: _____ Date From: _____ Date To: _____

Unit Name: _____

Unit Address: _____

	EMERGENCY WORKER NAME	CARD NO.	DATE		DATE		DATE		TOTAL HOURS	ROUND TRIP MILES
			TIME IN	TIME OUT*	TIME IN	TIME OUT*	TIME IN	TIME OUT*		
1										
2										
3										
4										
5										
6										
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28										
29										
30										

** Actual Incident Check Out Time.*

TOTAL PERSONNEL _____ TOTAL HOURS _____ TOTAL MILEAGE: _____

THIS FORM MUST BE SIGNED BY LOCAL EMERGENCY MANAGEMENT DIRECTOR/COORDINATOR OR SHERIFF'S DEPUTY

By my signature below, I certify that these persons did participate in this mission in accordance with WAC 118-04-220:

_____ Print Name and Title

_____ Signature and Date