

CHECK-IN LIST				1. Incident Name: Mission #			2. Operational Period:		Date From: Time From:	Date To: Time To:	
3. TEAM/UNIT NAME:						4. CHECK-IN LOCATION:					
	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.
	DEM #	UNIT	Team	PRINT NAME	CELL PHONE	Left Home	Arrive Scene	Depart Scene	Arrive Home	Miles	Claim <input checked="" type="checkbox"/>
1											<input type="checkbox"/>
2											<input type="checkbox"/>
3											<input type="checkbox"/>
4											<input type="checkbox"/>
5											<input type="checkbox"/>
6											<input type="checkbox"/>
7											<input type="checkbox"/>
8											<input type="checkbox"/>
9											<input type="checkbox"/>
10											<input type="checkbox"/>
11											<input type="checkbox"/>
12											<input type="checkbox"/>
13											<input type="checkbox"/>
PREPARED BY Name: _____ Position/Title: _____ Signature: _____ ICS 111-SAR-COVID ____ of ____ Date/Time: _____											