IDAHO OFFICE OF EMERGENCY MANAGEMENT
INCIDENT REPORT
STATE COMM NUMBER: _____

AGENCY SUBMITTING CLAIM:_____INCIDENT DATE:_____

RESPONDING AGENCY (IES)
ADDRESS(S):_____

_____

COMPLETED BY:_____PHONE #:_____

E-MAIL ADDRESS:_____

INCIDENT LOCATION:_____

CITY:_____COUNTY:_____ZIP:_____

GPS COORDINATES (If available):_____

TIME RESPONSE BEGAN:_____ENDED:_____

INCIDENT COMMANDER:_____AGENCY:_____

RESPONSE TEAM LEADER_____RRT:_____

SOURCE/CAUSE OF RESPONSE:_____

_____

RESPONSIBLE PARTY/SUSPECT:_____

_____

CONTACT NAME:_____TITLE: _____

MAILING ADDRESS:_____CITY:_____STATE:_____ZIP:_____

TELEPHONE:_____MESSAGE PHONE:_____

INSURANCE COMPANY:_____AGENT:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

TELEPHONE:_____MESSAGE PHONE:_____

INCIDENT INFORMATION:

SUBSTANCE(S) INVOLVED:

SUMMARY OF RESPONSE ACTION:

ADDITIONAL INFORMATION

DOCUMENTATION ATTACHED:

PHOTOS: ☐ VIDEO: ☐ RECEIPTS: ☐ NARRATIVE/TIMELINE: ☐

IDAHO OFFICE OF EMERGENCY MANAGEMENT
COST RECOVERY PROGRAM
4040 Guard St., Bldg. 600
Boise, ID 83705-5004

PERSONNEL COSTS - Idaho Code Section 39-7109(b)

DIRECTIONS: Please complete this form for reimbursement if employee costs were incurred for the time and efforts devoted specifically to this response that are not otherwise provided for in your operating budget. For example: overtime pay, recalled personnel and personnel paid for responding out of jurisdiction. Record their hourly pay including your department's benefits rate, whether they worked OT, recalled, or were paid on call, total response hours, a brief description of their on-scene duties and indicate their appropriate training level(s).

DEPARTMENT NAME: **TRAINING LEVEL**

Name	Duty Status (OT, Recall, Paid on Call)	Hourly Rate Plus Benefits	Total Hours	Total Amount	On-Scene Duties	Awareness Operations Technician Incident Command
TOTALS				$ 0		

EMPLOYER CERTIFICATION: I hereby certify that all personnel cost listed herein are for overtime and/or recalled personnel only. I further certify that all information contained on this form is true and correct to the best of my knowledge.

_____ _____
Signature Date

_____
Title

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MEDICAL TREATMENT - Idaho Code Section 39-7109(g)

DIRECTIONS: Please complete this section for reimbursement of medical treatment costs for response personnel. Receipts for services provided must be attached.

DEPARTMENT NAME:

Name	Description of Medical Treatment	Total Cost
TOTALS		**$** 0

VEHICLES AND APPARATUS - Idaho Code Section 39-7109(c) and (d)

DIRECTIONS: Please complete this section for reimbursement of vehicles and apparatus used specifically for the response. Indicate if the amount claimed is for rental, leasing or replacement. Receipts must be attached.

DEPARTMENT NAME:

Item	Rent Lease or Replace	Qty	Total Hours	Unit Cost or Hourly Rate	Total Cost
TOTALS					**$** 0

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MATERIALS/SUPPLIES/DECON - Idaho Code Section 39-7109 (a),(e) and (i)

DIRECTIONS: Please complete this section for reimbursement of materials, supplies and decon of equipment costs incurred as a result of the incident. Receipts for these costs must be attached.

DEPARTMENT NAME:

Item	Qty	Unit Cost	Total Cost
TOTALS			**$** 0

MISCELLANEOUS/TECHNICAL SERVICES/LAB COSTS - Idaho Code Section 39-7109 (b), (f) and (h)

DIRECTIONS: Please complete this section for reimbursement of miscellaneous costs, technical services and lab costs utilized specifically for the response. Receipts must be attached.

DEPARTMENT NAME:

Item or Technical Advisor	Qty	Unit Cost or Hourly Rate	Total Cost
TOTALS			**$** 0

SAMPLE SUMMARY LETTER

(Your Department Letterhead)

(DATE)

Idaho Office of Emergency Management
Attn: Yolandi Faulkner
4040 Guard St., Bldg. 600
Boise, ID 83705-5004

Re: Invoice for HM Response STATECOMM #:
Date of incident:

Please consider this letter an invoice for reimbursement in response to the above referenced hazardous materials incident.

Please send payment to (Agency)
Address

The costs relating to the incident are as follows:

1.	Personnel Overtime Costs	$1,610.00
2.	Medical Monitoring/Treatment	300.00
3.	Vehicles and Apparatus	80.00
4.	Disposal Material/Supplies	120.00
5.	Decon/Disposal	10.00
6.	Miscellaneous/Technical/Lab Costs	.00
	Total	$2,120.00

* I hereby certify that all the costs submitted were incurred as a result of response to this incident and that we have not nor will receive payment for these costs from any other source. I certify that the personnel costs are for overtime pay and recalled personnel. These costs would not have been incurred had the incident not occurred.

Sincerely,

(Person submitting cost)

*Please make sure this paragraph is included in your cover letter. Thanks.