

LOUISIANA Department of Health	1. Operational Period:				DAILY ACTIVITY LOG ICS 214 AMB	
	From:	Date:		To:		
		Time:			Time:	
3. Agency/Provider Name:				4. Placard #		
5. Actions/Notes/Assignment/Activities						
PCR #:	Start Time	End Time	Description of Activity: (Address/Origin & Destination of Mission/Transport)			
6. Prepared by: I certify that the above information is true and correct. This signatures are of the medics completing this form.	Print Name Medic #1:		Signature:		DATE:	
	Print name Medic #2		Signature:		DATE:	