EMPLOYEE EMERGENCY CONTACT FORM

|  |  |
| --- | --- |
| **Name** | **[Name]** |
| **Department** | **[Department]** |

# Personal Contact Info:

|  |  |
| --- | --- |
| **Home Address** | **[Home Address]** |
| **City, State, ZIP** | **[City, State, ZIP]** |
| **Home Telephone #** | **[Home Telephone #]** |  |  |
| **Cell #** | **[Cell #]** |
| **Email Address** | **[Email Address]** |

# Emergency Contact Info:

|  |  |
| --- | --- |
| 1. **Name**
 | **[Name]** |
| **Relationship** | **[Relationship]** |
| **Address** | **[Address]** |
| **City, State, ZIP** | **[City, State, ZIP]** |
| **Home Telephone #** | **[Home Telephone #]** |
| **Cell #** | **[Cell #]** |
| **Work Telephone #** | **[Work Telephone #]** |
| **Employer** | **[Signature]** |

|  |  |
| --- | --- |
| 1. **Name**
 | **[Name]** |
| **Relationship** | **[Relationship]** |
| **Address** | **[Address]** |
| **City, State, ZIP** | **[City, State, ZIP]** |
| **Home Telephone #** | **[Home Telephone #]** |
| **Cell #** | **[Cell #]** |
| **Work Telephone #** | **[Work Telephone #]** |
| **Employer** | **[Signature]** |

# Medical Contact Info:

|  |  |
| --- | --- |
| **Doctor Name** | **[Doctor Name]** |
| **Phone #** | **[Phone #]** |
| **Known Allergies** | **[Known Allergies]** |
| **Preferred Hospital** | **[Preferred Hospital]** |

 [ ]  I have voluntarily provided the above contact information and authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and its representatives to contact any of the above on my behalf in the event of an emergency.

|  |  |  |
| --- | --- | --- |
| **[Signature]** |  | **[MM/DD/YYYY]** |
| **Employee Signature** |  | **Date** |