**EMPLOYEE EMERGENCY CONTACT FORM**

Should you incur serious illness or injury during work hours, do you give permission to transport you to the nearest medical facility?

|  |  |
| --- | --- |
| [ ]  **Yes**  | [ ]  **No**  |

**DETAILS**

|  |  |
| --- | --- |
| **Name** | **[Full Name]** |
| **Home Address** | **[Home Address]** |
| **City, State, ZIP** | **[City, State, ZIP]** |
| **Home Phone Number** | **[Home Phone Number]** |  |  |
| **Cell Phone #** | **[Cell Phone #]** |
| **Email Address** | **[Email Address]** |

Please list the details of two people to be contacted in the event of an emergency.

**EMERGENCY CONTACT 1**

|  |  |
| --- | --- |
| **Name** | **[Full Name]** |
| **Home Address** | **[Home Address]** |
| **City, State, ZIP** | **[City, State, ZIP]** |
| **Home Phone Number** | **[Home Phone Number]** |  |  |
| **Cell Phone #** | **[Cell Phone #]** |
| **Email Address** | **[Email Address]** |

**EMERGENCY CONTACT 2**

|  |  |
| --- | --- |
| **Name** | **[Full Name]** |
| **Home Address** | **[Home Address]** |
| **City, State, ZIP** | **[City, State, ZIP]** |
| **Home Phone Number** | **[Home Phone Number]** |  |  |
| **Cell Phone #** | **[Cell Phone #]** |
| **Email Address** | **[Email Address]** |

Please provide details of the physician or health care provider that you would like us to contact in the event of an emergency:

**MEDICAL CONTACT**

|  |  |
| --- | --- |
| **Name** | **[Full Name]** |
| **Home Address** | **[Home Address]** |
| **City, State, ZIP** | **[City, State, ZIP]** |
| **Home Phone Number** | **[Home Phone Number]** |  |  |
| **Cell Phone #** | **[Cell Phone #]** |