EMPLOYEE EMERGENCY INFORMATION

Name: _____ D.O.B: _____/_____/_____

Address: _____
Street City State Zip

Home Phone: (_____)_____ Cell/Pager: (_____)_____

Alternate #: (_____)_____

Insurance Company: _____ Policy #: _____

In case of an emergency please contact:

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Home Phone #: (_____)_____ Work #: (_____)_____

Cell/Pager #: (_____)_____ Other #: (_____)_____

Doctor: _____ Number: (_____)_____

Dentist: _____ Number: (_____)_____

In case of an emergency, I wish to be transported to _____,
or the nearest available source of assistance.

Allergies & Special Precautions or Treatment: _____
_____

List any current medications being administered and why: _____
_____

List any chronic physical problems and any history of hospitalization: _____
_____

List any diseases you have had: _____
_____