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: ______________________________ Home Address: ______________________________ City: ____________ State: ____________ Zip: ____________ Home Phone Number: ____________ Cell Phone: ____________ Email: ______________________________
	Please list the details of two people to be contacted in the event of an emergency.
EMERGENCY CONTACT 1	Name: ______________________________ Home Address: ______________________________ City: ____________ State: ____________ Zip: ____________ Home Phone Number: ____________ Cell Phone: ____________ Email: ______________________________
EMERGENCY CONTACT 2	Name: ______________________________ Home Address: ______________________________ City: ____________ State: ____________ Zip: ____________ Home Phone Number: ____________ Cell Phone: ____________ Email: ______________________________
MEDICAL CONTACT	Please provide details of the physician or health care provider that you would like us to contact in the event of an emergency: Name: ______________________________ Home Address: ______________________________ City: ____________ State: ____________ Zip: ____________ Home Phone Number: ____________ Cell Phone: ____________