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: ____

EMERGENCY CONTACTS

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

Name: ____

Home Address: ____

City: ______________ State: ________________ Zip: ________________

Home Phone Number: ________________ Cell Phone: ______________

Name: ____

Home Address: ____

City: ______________ State: ________________ Zip: ________________

Home Phone Number: ________________ Cell Phone: ______________

MEDICAL CONTACTS

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: ______________