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? No ☐ Yes ☐

Do you have any allergies? No ☐ Yes ☐ _____

Do you have any medical alert/s? No ☐ Yes ☐ _____

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: _____

EMERGENCY CONTACT 2

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone: _____

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: _____