Rev. 134B0AC

EMPLOYEE EMERGENCY CONTACT FORM

Employee Contact

Name: _____ Title/Department: _____

Home Address: _____

Cell Phone: _____ Home Phone: _____

Primary Emergency Contact

Name: _____ Relationship: _____

Home Address: _____

Cell Phone: _____ Work Phone: _____

Secondary Emergency Contact

Name: _____ Relationship: _____

Home Address: _____

Cell Phone: _____ Work Phone: _____

Medical Contact

Doctor/Clinic Name: _____ Phone: _____

Voluntary Disclosure of Emergency Medical Information

Providing critical medical details, such as food allergies, can assist us in responding to the event of a medical emergency. If you would like to disclose any medical information, kindly use the space provided below.

Allergies:

_____

Medical Conditions:

_____

By sharing my contact information above, I authorize _____ [Employer Name] and its representatives to contact any of the listed contacts on my behalf during an emergency.

Employee Signature: _____

Date: _____