

**Emergency Information / Physician Designation**  
 California Department of Human Resources  
 State of California

Every employee is required to complete this page.

The information provided will be used for Emergency purposes only or as required by law under extraordinary circumstances. Upon completion of the form, you must return it to the Personnel Office for filing. You may provide a copy to your supervisor at your discretion. Should your information change, it is your responsibility to submit a revised form. Changes to your Emergency Contact Information, may require that you update some/all of the forms below. Please check with the Personnel Office for additional information or copies of these forms.

- PERS BSD - Beneficiary Designation
- STD Form 243 - Designation of Person(s) Authorized to Receive Warrants
- STD Form 686 - Employee Action Request (EAR)
- PERS HBD 12 - Health Benefit Enrollment Form
- STD Form 692 - Dental Plan Enrollment Authorization

Emergency Information			
Employee Name (Last)	(First)	(Middle Initial)	Birthday
Home Address (Number and Street)	City / State		Zip Code
Home Telephone Number	Cell Telephone Number		Division / Unit
In case of emergency, notify			
Primary Contact	Name		Relationship
	Address		Phone Number (Primary)
	City / State	Zip Code	Phone Number (Secondary)
Secondary Contact	Name		Relationship
	Address		Phone Number (Primary)
	City / State	Zip Code	Phone Number (Secondary)
Physician's Name			Phone Number (Primary)
Office Address (Include City/State/Zip Code)			Phone Number (Secondary)
Hospital Preference		Insurance Carrier	
Employee's Signature			Date Signed