

# EMPLOYEE EMERGENCY CONTACT FORM

Name \_\_\_\_\_

Department \_\_\_\_\_

## **Personal Contact Info:**

Home Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Cell # \_\_\_\_\_

## **Emergency Contact Info:**

(1) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Cell # \_\_\_\_\_

Work Telephone # \_\_\_\_\_ Employer \_\_\_\_\_

(2) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Cell # \_\_\_\_\_

Work Telephone # \_\_\_\_\_ Employer \_\_\_\_\_

## **Medical Contact Info:**

Doctor Name. \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone # \_\_\_\_\_

I have voluntarily provided the above contact information and authorize \_\_\_\_\_ and its representatives to contact any of the above on my behalf in the event of an emergency.

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_