



## EMPLOYEE EMERGENCY INFORMATION RECORD

Changes indicated below.

No changes to this form.

Name: \_\_\_\_\_

EMP Number: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

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

Work Location: \_\_\_\_\_

Phone No. (home): \_\_\_\_\_

Phone No. (work): \_\_\_\_\_

Phone No. (cell): \_\_\_\_\_

### IMMEDIATE SUPERVISOR

Name \_\_\_\_\_

Location \_\_\_\_\_

Phone No. \_\_\_\_\_

### PHYSICIAN

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. \_\_\_\_\_

### EMERGENCY NOTIFICATION(S)

List information below regarding persons whom you wish to be notified in the event of injury, illness, or emergency.

A. \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone No. \_\_\_\_\_ Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_

B. \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone No. \_\_\_\_\_ Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_

You are responsible for informing persons at your work site if you have a medical condition that may require immediate first aid. The human resources and/or safety officer in your agency can help you identify and inform these persons of your first aid requirements. Medical information is confidential. It is your decision and responsibility to inform others if you believe it necessary for your health and safety while at work.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**IMPORTANT – THIS INFORMATION SHOULD BE STORED IN THE EMPLOYEE'S PERSONNEL FILE. SUPERVISOR OR EMPLOYEES WHO WORK IN THE FIELD SHOULD HAVE IMMEDIATE ACCESS TO THIS INFORMATION.**

**(TO BE COMPLETED BY EVERY EMPLOYEE AND KEPT CURRENT)**