EMERGENCY NOTIFICATION FORM

DATE_____

DEPARTMENT:_____

EMPLOYEE NAME:_____

EMPLOYEE'S CELL PHONE #:_____

IN CASE OF AN EMERGENCY, WHO SHOULD BE CONTACTED:

NAME:_____ RELATIONSHIP:_____

PHONE NUMBER WHERE THEY CAN BE REACHED DURING YOUR WORKING HOURS:_____ alternate or cell phone #_____

(if above person can not be reached, alternate person to contact):

NAME:_____ RELATIONSHIP:_____

PHONE NUMBER WHERE THEY CAN BE REACHED DURING YOUR WORKING HOURS:_____ alternate or cell phone #_____

FAMILY DOCTOR:_____PHONE:_____

HOSPITAL PREFERENCE:_____

ANY OTHER INFORMATION (OR MEDICAL HISTORY) WHICH WOULD BE HELPFUL IN CASE OF EMERGENCY (include any medication you take; contact lenses/eyeglasses):

_____
_____
_____
_____

A COPY OF THIS FORM SHOULD BE KEPT WITHIN THE EMPLOYEE'S DEPARTMENT AND A COPY KEPT IN EMPLOYEE'S FILE IN PERSONNEL DEPARTMENT.
PLEASE UPDATE THIS INFORMATION WHEN A CHANGE IS NECESSARY.