



Employee Emergency Information

This information is confidential and voluntary

Employee Name (Last, First M.I.):

Department:

Position:

Date of Hire:

Home Address:

City:

State:

Zip:

Phone #1:

Phone #2:

Email Address:

In Case of Emergency Notify:

Name:

Relationship:

Home Address:

City:

State:

Zip:

Phone #1:

Phone #2:

Email Address:

If Unable to Reach Above Notify:

Name:

Relationship:

Home Address:

City:

State:

Zip:

Phone #1:

Phone #2:

Email Address:

Unusual Medical Conditions:

Please list Medicine/Substance Allergies:

Notice: In the event of an emergency or disaster, transportation and availability to medical service may be delayed. It is recommended that any required health sustaining medication be in your possession. A minimum of three (3) day supply is recommended.

Employee Signature: _____ Date: _____

Date updated: _____