**EMPLOYEE EMERGENCY INFORMATION**

Employee Name: Date:

In the event of a medical emergency, the following people and emergency medical personnel should be contacted:

Contact 1:

Phone: Relationship:

Contact 2:

Phone: Relationship:

Doctor: Phone:

In the event of an emergency please provide any of the following information you feel it would be necessary for an emergency care provider to know.

Insurance Carrier:

Medical Identification No.:

Medications, Allergies or Conditions etc.:

I , (Employee Name) have provided the above information to assist in the event of an emergency. By signing I give approval of my employer to maintain this information within my Medical/Confidential file.

Employee Signature Date

Witness Signature