**EMERGENCY CONTACT FORM**

Employee Name

Street Address Home Telephone Number

City State Zip Code Cell Number

# PERSONS TO CONTACT IN AN EMERGENCY

**First Contact: Second Contact:**

Name Name

Relation Relation

Street Address Street Address

City State Zip Code City State Zip Code

(Area Code) Telephone Number (home) (Area Code) Telephone Number (home)

(Area Code) Telephone Number (work) (Area Code) Telephone Number (work)

Cell Phone Number Cell Phone Number

***Optional Information***

*Date of Birth:*

*Physician Name: Phone:*

Please list any medications or health issues you may want an emergency responder to know in the event of a problem.

*Allergies:*

*Medications:*

*Health Issues:* \_

## EMPLOYEE SIGNATURE DATE