In Case of Emergency Form	It is the responsibility of every employee to inform HR Department regarding any changes.

I. GENERAL INFORMATION

Employee Name: OM SHARMA	Gender: M ☑ F ☐	Date of Birth: 19/11/2002
Current Address:		City: AGRA State: UP
Permanent Address: 6/36/25A SHASTRI NAGAR, NEAR T.P NAGAR AGRA		City: State:

Please provide your Family Details (Parents, Siblings, Spouse etc.)

Name: MR. HARISH CHANDRA		Relationship: FATHER
Phone: 9058659222	Address: SHASTRI NAGAR AGRA	
Name: MRS. MANJU SHARMA		Relationship: MOTHER
Phone: 8279960337	Address: SHASTRI NAGAR, AGRA	
Name: SAMRIDHI SHARMA		Relationship: SISTER
Phone:	Address: AGRA	
Name: ADITI SHARMA		Relationship: SISTER
Phone:	Address: AGRA	
Name:		Relationship:
Phone:	Address:	
Name:		Relationship:
Phone:	Address:	
Name:		Relationship
Phone	Address:	
Name:		Relationship:
Phone:	Address:	

Please provide the details of any of your friends		
Name: KRISHNAKANT SINGH	Location: AGRA	Profession:
Home Phone: 9520652959	Work Phone:	Cellular Phone:
Name:	Location:	Profession:
Home Phone:	Work Phone:	Cellular Phone:
Name:	Location:	Profession:
Home Phone:	Work Phone:	Cellular Phone:
IN CASE OF EMERGENCY PLEASE CONTACT		
Name: MR HARISH CHANDRA	Relationship: FATHER	
Home Phone: 9058659222	Work Phone:	Cellular Phone:
Name: MRS. MANJU SHARMA	Relationship: MOTHER	
Home Phone 8279960337	Work Phone	Cellular Phone:
Preferred Hospital:		
Physician's Name	Specialist Name:	Dentist Name:
Phone:	Phone:	Phone:
List all medications that you are taking (prescription and over the counter). If necessary include the reason of medication:		
List allergies to medicine, food or other allergens, and any medical information such as physical impairments and assistive devices, that emergency personal need to be aware of, attach documentation is necessary:		
II. SIGNATURE AND CONSENT FOR EMERGENCY MEDICAL TREATMENT		
Employee Signature:		Date Signed: 09/05/24.