

| | | |
|---|---|----------------------------------|
| In Case of Emergency Form | It is the responsibility of every employee to inform HR Department regarding any changes. | |
| I. GENERAL INFORMATION | | |
| Employee Name: Anant Kumar Srivastava | Gender: M <input checked="" type="checkbox"/> F <input type="checkbox"/> | Date of Birth: 22/08/2002 |
| Current Address: | City: | State: |
| Permanent Address: 56/886 chota bharawara vigyan khand 1 near avaneendra academy gomti nagar lucknow | City: Lucknow | State: U.P. |
| Please provide your Family Details (Parents, Siblings, Spouse etc.) | | |
| Name: Surayakant Srivastava | Relationship: Father | |
| Phone: 8707729595 | Address: 56/886 chota bharawara vigyan khand 1 near avaneendra academy gomti nagar lucknow | |
| Name: Renuka Srivastava | Relationship: Mother | |
| Phone: 6307444188 | Address: 56/886 chota bharawara vigyan khand 1 near avaneendra academy gomti nagar lucknow | |
| Name: Sakshi Sriastava | Relationship: Sister | |
| Phone: 8840644705 | Address: 56/886 chota bharawara vigyan khand 1 near avaneendra academy gomti nagar lucknow | |
| Name: | Relationship: | |
| Phone: | Address: | |
| 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: | Location: | Profession: |
| Home Phone: | 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: | Relationship: | |
| Home Phone: | Work Phone: | Cellular Phone: |
| Name: | Relationship: | |
| Home Phone | 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: |