In Case of Emergency Form		It is the responsibility of every employee to inform HR Department regarding any changes.		
I. GEN	IERAL INFORMATION	I		
Employee Name:	Gender: M□ F□	Date of Birth:		
Current Address:		City:	State:	
Permanent Address:		City:	State:	
Please provide your Fam	ily Details (Parents, S	Siblings, Spou	se etc.)	
Name:		Relationsh		
Phone:	Address:			
Name:		Relationship:		
Phone:	Address:	1		
Name:		Relationsh	nip:	
Phone:	Address:			
Name:		Relationsh	nip:	
Phone:	Address:	Address:		
Name:		Relationsh	nip:	
Phone:	Address:			
Name:		Relationsh	Relationship:	
Phone:	Address:			
Name:		Relationsh	nip	
Phone	Address:			
Name:		Relationsh	nip:	
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:		