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

| I. GENERAL INFORMATION | | |
|---|---|---|
| Employee Name: Jayesh Rotidas Dhumal. | Gender: M ☑ F ☐ | Date of Birth: 08/09/1998 |
| Current Address: | | City: State: |
| Permanent Address: A/10 OM Laxmi Vijaya so., Kumbharkhan pada . | | City: State: Dombivali Maharashtra |

| Please provide your Family Details (Parents, Siblings, Spouse etc.) | |
|---|---|
| Name: Rotidas Maruti Dhumal. | Relationship: Father. |
| Phone: 9819978306 | Address: A/10 OM Laxmi Vijaya so., Kumbharkhan pada, Dombivali W. |
| Name: Savita Rotidas Dhumal | Relationship: Mother. |
| Phone: 9833751490 | Address: A/10 OM Laxmi Vijaya so., Kumbharkhan pada, Dombivali W. |
| Name: Nikhil Rotidas Dhumal. | Relationship: Brother. |
| Phone: 8108965845 | Address: A/10 OM Laxmi, Vijaya so., Kumbharkhan pada, Dombivali W. |
| 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: Rohidas Maruti Dhumal. | Relationship: Father | |
| Home Phone: 9819978306. | 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: 03/11/2021 |