	miorini in Beparein	ent regarding any changes.	
I. GENERAL INFORMATION			
Employee Name: BASIL C PAUL	Gender: M√□ F□	Date of Birth: 09-03-1993	
Current Address: CHIRANGARA HOUSE,RAYAMANGALAM POST ,KURUPPAMPADY ,ERNAKULAM 683545		City:PERUMBAVOOR State: KERALA	
Permanent Address: CHIRANGARA HOUSE,RAYAMANGALAM POST ,KURUPPAMPADY ,ERNAKULAM 683545		City:PERUMBAVOOR State: KERALA	
Please provide your Family Details (Parents, Sib		lings, Spouse etc.)	
Name: PAULOSE CP		Relationship:FATHER	
Phone:9446688472	Address: CHIRANGARA HOUSE,RAYAMANGALAM POST ,KURUPPAMPADY ,ERNAKULAM 683545		
Name: MARY		Relationship:MOTHER	
Phone: 7208313638	Address: CHIRANGARA HOUSE,RAYAMANGALAM POST ,KURUPPAMPADY ,ERNAKULAM 683545		
Name:ASWATHY K SUKUMARAN		Relationship: WIFE	
Phone:9400946448	Address: CHIRANGARA HOUSE,RAYAMANGALAM POST ,KURUPPAMPADY ,ERNAKULAM 683545		
Name:		Relationship:	
Phone:	Address:		
Name:	I	Relationship:	
Phone:	Address:		
Name:		Relationship:	
Phone:	Address:	I	
Name:		Relationship	
Phone	Address:	<u>I</u>	
Name:	1	Relationship:	
Phone:	Address:	<u> </u>	

Please provide the details of any of your friends			
Name: RAKESH KU	Location: KERALA	Profession: IT	
Home Phone:	Work Phone:	Cellular Phone:8129820730	
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: ASWATHY K SUKUMARAN	Relationship:WIFE		
Home Phone:	Work Phone:	Cellular Phone:9400946448	
Name: RAKESH KU	Relationship: FRIEND		
Home Phone	Work Phone	Cellular Phone: 8129820730	
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:	OR EPILICIAL ME	Date Signed:19-05-2025	
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