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:	Address: SHASTRI NAGAR AGRA
Name: MRS. MANJU SHARMA	Relationship: MOTHER
Phone:	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:	Work Phone:	Cellular Phone:
Name: MRS. MANJU SHARMA	Relationship: MOTHER	
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: 09/05/24.