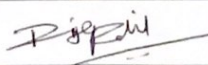


In Case of Emergency Form	It is the responsibility of every employee to inform HR Department regarding any changes.	
I. GENERAL INFORMATION		
Employee Name: Priyesh Ravindranath Patil.	Gender: M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Date of Birth: 14/09/1988
Current Address: A-3, Kool Breeze Society, Mohpada Road, Kathap, Badlapur (East)	City: Badlapur	State: Maharashtra
Permanent Address: Same as above.	City:	State:
Please provide your Family Details (Parents, Siblings, Spouse etc.)		
Name: Priyanka Priyesh Patil.	Relationship: wife.	
Phone: 9373433998	Address: A-3, Kool Breeze Society, Kathap, Badlapur East.	
Name: Ravindranath Gorindao Patil.	Relationship: father	
Phone: 8422967202	Address: A-3, Kool Breeze Society, Kathap, Badlapur East.	
Name: Malini Ravindranath Patil.	Relationship: Mother.	
Phone: 8422967201	Address: A-3, Kool Breeze Society, Kathap, Badlapur East.	
Name: Pranav Ravindranath Patil.	Relationship: Brother.	
Phone: 8830074244	Address: A-3, Kool Breeze Society, Kathap, Badlapur East.	
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: Snehal Mhaske.	Location: Koper Khairne	Profession: Job.
Home Phone: 8828285284	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: Priyanka Priyesh Patil.	Relationship: Wife.	
Home Phone: 9373433998.	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: 29/05/2025