

# EMPLOYEE EMERGENCY CONTACT FORM

TRY  smartsheet for FREE 

## EMPLOYEE INFORMATION

EMPLOYEE NAME		EMPLOYEE ID	
SSN		POSITION	
ADDRESS		PHONE 1	
		PHONE 2	
		EMAIL	
		DATE COMPLETED	

## EMERGENCY CONTACTS

CONTACT 1 NAME		RELATIONSHIP	
PHONE 1		PHONE 2	
ADDRESS			
CONTACT 2 NAME		RELATIONSHIP	
PHONE 1		PHONE 2	
ADDRESS			

## COMMENTS Please provide details fo any medical or personal info you would wish to be shared with an Emergency Care Provider.

ALLERGIES	
ALLERGIES TO MEDICATIONS	
MEDICATIONS CURRENTLY TAKEN	
OTHER	

## MEDICAL CONTACT INFO

DOCTOR NAME		PHONE	
DENTIST NAME		PHONE	
PREFERRED HOSPITAL		PHONE	

The above information has been provided voluntarily, and I authorize contact on my behalf in the event of an emergency.

EMPLOYEE SIGNATURE		DATE	
SUBMIT COMPLETED FORM TO		REC'D BY	
		DATE REC'D	

## **DISCLAIMER**

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