|  |
| --- |
| Employee / Supervisor Emergency Contact SheetInformation provided on this form will be used in an emergency only to notify specified individual(s) of a serious illness, injury, or incident. This information will remain confidential.*Submit a new form if this information changes.* *Email a copy to [Name] at [email address]. A hard copy of this sheet should be kept somewhere visible in your cubicle/office.*  |
| EMPLOYEE / SUPERVISOR INFORMATION  |

|  |  |
| --- | --- |
| **Name:**  | **Role**  |
| **Home Address:**  | **City:**  | **State/Zip:**  |
| **Home Phone #:**  | **Cell Phone #:**  |
| EMERGENCY CONTACT INFORMATION (list in the order to be contacted) |
| 1st Emergency Contact |
| **Name:**  | **Relationship:**  |
| **Home Phone #:**  | **Cell Phone #:**  |
| **Address:**  | **City, State, Zip:**  |
| 2nd Emergency Contact |
| **Name:**  | **Relationship:**  |
| **Home Phone #:**  | **Cell Phone #:**  |
| **Address:**  | **City, State, Zip:**  |
| 3rd Emergency Contact |
| **Name:**  | **Relationship:**  |
| **Home Phone #:**  | **Cell Phone #:**  |
| **Address:**  | **City, State, Zip:**  |

|  |  |
| --- | --- |
| Date Signed | Employee / Supervisor Signature |
|  |  |

If you choose to provide additional medical information, please complete the back side of this form.

This medical information will be accessible in a medical or potentially life-threatening EMERGENCY ONLY, to notify paramedics, emergency response, and/or specified individual(s).

|  |
| --- |
| Additional Information (voluntary) |
| Please list any health considerations or any information you would like a care provider to know in case of emergency (food/drug/insect allergies, current medications, diabetes, epilepsy, etc.) |
|  |