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EMERGENCY CONTACT FORM

EMPLOYEE NAME	EMPLOYEE ID	DEPARTMENT / LOCATION	MOBILE PHONE	DATE

PRIMARY EMERGENCY CONTACT

Name _____

Relationship _____

Mobile phone _____

Alternate phone _____

Email _____

Address _____

SECONDARY EMERGENCY CONTACT

Name _____

Relationship _____

Mobile phone _____

Alternate phone _____

Email _____

Address _____

MEDICAL (VOLUNTARY)

Physician / clinic _____

Physician phone _____

Preferred hospital _____

Blood type _____

INSURANCE (VOLUNTARY)

Health insurer _____

Member / policy no. _____

Insurer phone _____

Group no. _____

ALLERGIES, CONDITIONS OR MEDICATIONS YOU WANT RESPONDERS TO KNOW ABOUT (VOLUNTARY)

This form is kept in a sealed envelope in the personnel file and with the site first-aid station, is opened only in an emergency, and is reviewed once a year. Medical details are voluntary and are stored separately from the general personnel file.

Employee signature / date _____

Received by (HR) / date _____