

# EMERGENCY INFORMATION

[Company Name]

EMPLOYEE NAME	EMPLOYEE NUMBER	SOCIAL SECURITY NUMBER
POSITION	DEPARTMENT	MANAGER
WORK PHONE	HIRE DATE	TODAY'S DATE

EMPLOYEE'S HOME INFORMATION		
HOME PHONE	CELL PHONE	PAGER
STREET	CITY, STATE AND ZIP	

EMERGENCY CONTACT—1			
NAME	HOME PHONE	WORK PHONE	CELL PHONE
STREET	CITY, STATE AND ZIP		
RELATIONSHIP TO EMPLOYEE			

EMERGENCY CONTACT—2			
NAME	HOME PHONE	WORK PHONE	CELL PHONE
STREET	CITY, STATE AND ZIP		
RELATIONSHIP TO EMPLOYEE			

**PHYSICIAN INFORMATION—1**

<b>NAME</b>	<b>PHONE NUMBER</b>
<b>STREET</b>	<b>CITY, STATE AND ZIP</b>
<input type="checkbox"/> GP <input type="checkbox"/> OB/GYN <input type="checkbox"/> Dentist <input type="checkbox"/> Eye Doctor <input type="checkbox"/> Allergist	

**PHYSICIAN INFORMATION—2**

<b>NAME</b>	<b>PHONE NUMBER</b>
<b>STREET</b>	<b>CITY, STATE AND ZIP</b>
<input type="checkbox"/> GP <input type="checkbox"/> OB/GYN <input type="checkbox"/> Dentist <input type="checkbox"/> Eye Doctor <input type="checkbox"/> Allergist	

**PHYSICIAN INFORMATION—3**

<b>NAME</b>	<b>PHONE NUMBER</b>
<b>STREET</b>	<b>CITY, STATE AND ZIP</b>
<input type="checkbox"/> GP <input type="checkbox"/> OB/GYN <input type="checkbox"/> Dentist <input type="checkbox"/> Eye Doctor <input type="checkbox"/> Allergist	