Ohio Department of Medicaid

EMPLOYEE EMERGENCY INFORMATION

ODM employees are provided this form for completion. Submission of this form is voluntary so that basic contact and medical information is available in the event of an emergency. Employees are encouraged to complete the form with as much information as they feel comfortable submitting. If you opt-out of providing any information please indicate in the check box below. All forms must be submitted according to the instructions listed below.

Name	Date
Home Address	
Home Phone	Alt. Phone

☐ I am choosing to not provide any information regarding my emergency contacts and medical information. I understand that this information is requested solely to aid medical personnel in providing care for me during a medical emergency.

EMERGENCY CONTACT INFORMATION

Name	Home Phone
Relationship	Alt. Phone
Employer	Work Phone

Name	Home Phone
Relationship	Alt. Phone
Employer	Work Phone

INCLUDED

Please indicate what documents you have voluntarily included with this form.

- ☐ Copy of Health/Insurance Card
- ☐ Copy of Prescription Card
- ☐ Copy of Driver's License
- ☐ Copy of Living Will
- ☐ Copy of Medical Power of Attorney

INSTRUCTIONS

When you have finished completing this form, place it and any copies of documents in the provided red envelope. Place the envelope in a conspicuous area within your cubicle or office, where it can be found easily, in case of a medical emergency.

MEDICAL INFORMATION

Healthcare Insurance Carrier	
Doctor's Name	Phone
Specialist Name	Phone
Preferred Hospital	Phone

KNOWN ALLERGIES

Please indicate any allergies, such as food, insect bites, adhesive, medicines, etc.

OTHER INFORMATION A MEDICAL PROFESSIONAL SHOULD KNOW

Please provide any information that will help a medical professional provide aid, such as but not limited to: medications being taken and for what, health conditions, contacts, dentures, partials, hearing loss, hearing aids, pacemakers.