

EMPLOYEE EMERGENCY INFORMATION FORM INSTRUCTIONS

1. Note: you will need the most current version of Adobe Reader to fill out this form.
2. To insert your passport photo, click on the square and navigate to your photo. Your photo needs to be approximately 200 X 200 pixels and under 4 kbs. If your photo needs to be resized, do this in another program before inserting it into this form.
3. In the last box on page 2, write your organization's name in the blank field included in the wording "I have voluntarily provided the above contact information and authorize _____ and its representatives to contact any of the above on my behalf in the event of an emergency."
4. After completing the form be sure to save it, and then print it. Include your signature in the designated area at the bottom of page 2. Next, send the form to your organization's designated individual or department. Keep one printed copy on file for your own records.
5. To email the completed form, first save your form by going to File>>Save As, then indicate where you would like it saved. Once your form is saved, go to File>>Attach to email.

EMPLOYEE EMERGENCY INFORMATION

Last Updated:

PERSONAL INFORMATION

Click to Insert
Passport Photo

First, Middle, Last Name: _____

Department: _____

DOB: _____ Place of Birth: _____

SSN: _____ Blood Type: _____

Identifying Scars/Tattoos: _____

Spouse Name: _____

Passport (10 Yr) Number: _____

Country of Issue: _____

Date of Issue: _____ Date of Expiration: _____

Passport (2 Yr) Number: _____

Country of Issue: _____

Date of Issue: _____ Date of Expiration: _____

Driver's License Number: _____

State/Country of Issue: _____

International Driver's License: Y N

Home Address: _____ Home Telephone: _____

_____ Cellular: _____

Email Address: _____

EMERGENCY CONTACT (1):

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cellular: _____

Work Phone: _____

Email: _____

Special Instructions: _____

EMERGENCY CONTACT (2):

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Cellular: _____

Work Phone: _____

Email: _____

Special Instructions: _____

Alert Code (1 to 2 word max): _____
SOS Member Number: _____

PRIMARY CARE PHYSICIAN

Name: _____
Address: _____ **Telephone:** _____
_____ **Email:** _____

HEALTH INSURANCE

Policy No: _____
Name: _____
Address: _____ **Telephone:** _____
_____ **Email:** _____

DENTAL INFORMATION

Name: _____
Address: _____ **Telephone:** _____
_____ **Email:** _____ **Policy No:** _____

KNOWN MEDICAL CONDITIONS

PRESCRIPTIONS

SPECIAL INSTRUCTIONS

I have voluntarily provided the above contact information and authorize _____
and its representatives to contact any of the above on my behalf in the event of an emergency.

Employee Signature: _____ **Date:**