

# EMERGENCY NOTIFICATION FORM

DATE \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_

EMPLOYEE'S CELL PHONE #: \_\_\_\_\_

IN CASE OF AN EMERGENCY, WHO SHOULD BE CONTACTED:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER WHERE THEY CAN BE REACHED DURING YOUR WORKING  
HOURS: \_\_\_\_\_ alternate or cell phone # \_\_\_\_\_

(if above person can not be reached, alternate person to contact):

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER WHERE THEY CAN BE REACHED DURING YOUR WORKING  
HOURS: \_\_\_\_\_ alternate or cell phone # \_\_\_\_\_

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FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOSPITAL PREFERENCE: \_\_\_\_\_

ANY OTHER INFORMATION (OR MEDICAL HISTORY) WHICH WOULD BE HELPFUL  
IN CASE OF EMERGENCY (include any medication you take; contact lenses/eyeglasses):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A COPY OF THIS FORM SHOULD BE KEPT WITHIN THE EMPLOYEE'S DEPARTMENT  
AND A COPY KEPT IN EMPLOYEE'S FILE IN PERSONNEL DEPARTMENT.  
PLEASE UPDATE THIS INFORMATION WHEN A CHANGE IS NECESSARY.