EMPLOYEE PERSONAL PROFILE FORM

Profile Information: The information requested in this questionnaire is voluntary and confidential, and is not to be used for any purpose other than during an actual emergency. The contents of this questionnaire must be kept in a sealed envelope in a secure area and it will not be opened unless in the case of an actual emergency. The contents of this questionnaire and your photograph will be updated annually during your performance evaluation.

Personal Identifying Information:

Your name:

Nickname or other names used:

Employment classification:

Employment location:

Permanent residence:

Telephone:

Secondary residence:

Telephone:

Other employment, if applicable:

Date of birth: / / Place of birth:

Name of hospital: Mother's name:

Race: Sex: Complexion:

Height: Weight: Hair color: Eye color:

Scars/marks/tattoos:

Hobbies:

Are your fingerprints and a current photograph on file with this institution?
Yes ___ No ___

Your Family And Emergency Notification Information:

Marital status: Anniversary date: / /

Name of spouse/roommate: Nickname:

Name of child: Birth date: / /

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Persons To Contact In Case Of Emergency:

Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:

Your Immediate Close Relatives:

Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:

Other Persons Living Or Working In Your Household:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Your Motor Vehicles:

Year: Make:		Model:	Color:
License:	Driven by:		
Year: Make:		Model:	Color:
License:	Driven by:		
Year: Make:		Model:	Color:
License:	Driven by:		

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Your Medical Information:

Physician:

Address: Phone:

Physician:

Address: Phone:

Hospital:

Address: Phone:

Blood type: Allergic to:

Medical condition(s) requiring treatment or medication:

Treatment or medication:

Medical condition(s) requiring treatment or medication:

Treatment or medication:

I authorize my physician(s) to release confidential information in the event of an emergency situation requiring treatment.

Signed: Date:

EMPLOYEE:

After completing this form, place the form into the envelope provided and seal the envelope. Write your name (last, first, middle initial) and Social Security number on the face of the envelope. Deliver the sealed envelope to your reviewer. Please include any other information you feel is necessary on a separate page, to be included with this profile.

REVIEWER:

Ensure that the employee's envelope is securely sealed and completed as indicated. Initial and date the face of the envelope and store it in a secure area.

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