

EMERGENCY CONTACT FORM

You are strongly encouraged to complete this form, so that the person of your choice is notified in the event of an emergency. Any medical information you choose to disclose will be maintained confidentially and will only be disclosed to medical personnel as necessary.

Employee Name

Date

In case of emergency, contact:

Contact Name

Relationship to you

Phone

Cell Phone

If you have a preference of hospital to which you would be taken if necessary, please indicate the hospital below:

If you wish us to inform emergency personnel of any medical/health condition, please describe below—or write none:

By signature below, I authorize my employer to disclose the medical information stated above to emergency personnel in the event of an emergency.

Dated: _____

Employee