Employee Emergency Contact and Medical Information Form

Please complete this form to ensure the company has accurate information in case of an emergency. This information will be kept confidential.

---

1. Employee Information

Full Name:		Employee ID:	
Department:		Job Title:	
Home Phone:		Mobile Phone:	
Home Address:			

---

2. Primary Emergency Contact

Contact Name:		Relationship:	
Primary Phone:		Alternate Phone:	
Home Address:			

---

3. Secondary Emergency Contact

Contact Name:		Relationship:	
Primary Phone:		Alternate Phone:	
Home Address:			

---

4. Medical Information

Providing medical information is voluntary, but highly recommended in case of a medical emergency.

Primary Care Physician:		Physician Phone:	
Preferred Hospital:			
Blood Type:			
Known Allergies (Food, Drug, Insect, etc.):			
Current Medical Conditions:			
Current Medications:			
Other Relevant Medical Info:			

---

5. Authorization and Signature

I confirm that the information provided above is accurate and complete to the best of my knowledge. In the event of an emergency, I authorize the company to contact the individuals listed above and release this medical information to emergency medical personnel.

Employee Signature:		Date:	