

Hospital Volunteer Emergency Contact Information Form

Please complete this form. This information will be kept on file in the Volunteer Services Department and used only in the event of an emergency.

Volunteer Personal Information

Full Name:

Primary Phone Number: Alternative Phone Number:

Email Address: Date of Birth (MM/DD/YYYY):

Street Address:

City: State: Zip Code:

Primary Emergency Contact

Contact Full Name:

Relationship to Volunteer:

Primary Phone Number: Alternative Phone Number:

Email Address:

Secondary Emergency Contact

Contact Full Name:

Relationship to Volunteer:

Primary Phone Number: Alternative Phone Number:

Email Address:

Medical Information (Optional)

Primary Care Physician Name: Physician Phone:

Known Allergies (including medications):

Relevant Medical Conditions:

Authorization & Signature

I authorize the hospital staff to contact the individuals listed above in the event of an emergency.

Volunteer Signature (Print Name for digital form): Date: