Intern Emergency Contact and Medical Information Form

Please complete this form clearly. This information will be kept confidential and used only in the event of an emergency.

1. Intern Personal Information

Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Current Address:

Department/Division:

2. Primary Emergency Contact

Contact Person Name:

Relationship to Intern:

Primary Phone Number:

Alternate Phone Number:

Email Address:

Home Address:

3. Secondary Emergency Contact

Contact Person Name:

Relationship to Intern:

Phone Number:

Email Address:

4. Medical Information

Blood Type:

Allergies (Food, Medication, Environmental):

Chronic Medical Conditions:

Current Medications:

Health Insurance Provider:

Policy / Group Number:

Primary Care Physician Name:

Physician Phone Number:

5. Consent and Authorization

In the event of a medical emergency, I hereby authorize the organization to contact the individuals listed above and to secure necessary medical treatment if I am unable to do so.

Intern Signature (Print Name to Sign):

Date (MM/DD/YYYY):