

Employee Name _____ Date _____

Job Title/Department _____ DOB _____

The following information will be kept in your personnel file in the event you are ever injured or there is an unforeseen act of nature that occurs in our area. We will use this information only when necessary and all information will be kept in the HR files for privacy. Please update this as often as you need (blank copy is available on website under “Employee Links”) and return to Administrative Services.

All requested fields are strictly voluntary so please complete only as much information as you feel comfortable.

CONTACT INFORMATION	CELL PHONE	WORK/ OTHER PHONE
Primary Contact Name		
Primary Contact Address		
Relationship to You		
Secondary Contact Name: Address		
Secondary Contact Address		
Primary Physician Contact Information		
Known Allergies		
Preferred Medical Facility (if non-life threatening)		

Other Emergency Information

Please list any additional information that would be beneficial in the event you are unable to speak for yourself or your emergency contacts cannot be located (i.e., Pertinent known medical conditions, prescriptions, DPA, DNR, etc.), use the reverse side of this form if necessary.