



## Employee Emergency Contact Form

*Please return this form to the  
Office of Human Resources*

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**In the event of an emergency, please list the names and telephone numbers of two individuals you would like us to contact:**

### Emergency Contact #1:

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

### Emergency Contact #2

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Do you give us permission to transport you to the nearest medical facility should you incur serious illness or injury during normal work hours?

☐

Yes

☐

No

If yes, please indicate the name and contact telephone number of the physician or health care provider that you would like for us to contact:

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_