



EMPLOYEE EMERGENCY CONTACT FORM

CONFIDENTIALITY NOTICE: *This form is strictly confidential. Access is restricted to designated safety, first aid, and human resources personnel on a strict 'need-to-know' basis.*

Personal Information (Required):

Your Name: _____

Position: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Primary Emergency Contacts (Required):

Name _____ Relationship _____

Phone(s) _____

Name _____ Relationship _____

Phone(s) _____

Voluntary Medical Information (Optional):

Providing the following information is entirely voluntary. This data will only be utilized by first responders or medical personnel in the event of a life-threatening medical emergency during work hours.

Preferred Hospital/Medical Facility: _____

Critical Medical Conditions or Severe Allergies (e.g., Penicillin, Peanuts, Bee Stings) that first responders should be aware of: _____

Special requests or other vital information you'd like to disclose, if any: _____

☐ By checking this box, I do not want ISD personnel to release my home address to other ISD employees.

☐ By checking this box, I give permission to the ICISD to discuss financial and medical situations with the named above or listed here: _____

Signature _____ Date _____