



# Human Resources

Emergency Contact Information

PRIMARY DATA ENTRY

This information is vital in the event of an accident or medical emergency

NAME	LAST	FIRST	MI	S.S. NUMBER
ADDRESS			ADDRESS 2	
CITY			STATE	ZIP
PHONE (Home)			DRIVERS LIC #	PHONE (Cell)
EMAIL			FULL-TIME	PART-TIME CONTRACT

## Primary Emergency Contact

NAME	LAST	FIRST	RELATIONSHIP
PHONE (Home)			PHONE (Cell)

## Secondary Emergency Contact

NAME	LAST	FIRST	RELATIONSHIP
PHONE (Home)			PHONE (Cell)

## Preferred Local Hospital

INSURANCE INFORMATION	COMPANY	POLICY NUMBER
OTHER COMMENTS		

## Electronic Signature

I CERTIFY BY SIGNING THIS ONLINE FORM THAT THE FOREGOING INFORMATION IS TRUE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

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TYPE YOUR NAME HERE

TODAY'S DATE

PRINT

SUBMIT

CLEAR