

# CITY OF HOKAH CONTACT INFORMATION

Document 2009-03

## Employee Emergency Contact Database

*PRINCIPAL PURPOSE(S) for which information is intended to be used:*

*(1) Person(s) to be notified in case of emergency (2) Medical Info. (3) Provides several means of contacting Employees/Council during an emergency.*

**Employee Information as of** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

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

Home Address: \_\_\_\_\_  
Street Address City State Zip code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other Phones / Cell Phones / Pagers: \_\_\_\_\_ / \_\_\_\_\_

E-mail (Home): \_\_\_\_\_ E-mail (Work): \_\_\_\_\_

## Emergency Contacts

### Primary person to be notified in case of an emergency:

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

Relationship: Relative \_\_\_\_\_ Friend \_\_\_\_\_ Other \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street Address City State Zip code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### Secondary person to be notified in case of emergency:

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

Relationship: Relative \_\_\_\_\_ Friend \_\_\_\_\_ Other \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street Address City State Zip code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Medical Information:**

Physician's

Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's

Name \_\_\_\_\_ Phone \_\_\_\_\_

Hospital of Choice \_\_\_\_\_ *(EMT or Paramedic may override choice)*

Medications/Allergy/Other \_\_\_\_\_

Veteran \_\_\_ Yes \_\_\_ No-----Smoker \_\_\_ Yes \_\_\_ No-----Diabetic \_\_\_ Yes \_\_\_ No

Religious/spiritual organization \_\_\_\_\_

Contact Information \_\_\_\_\_

Insurance Information \_\_\_\_\_ Policy # \_\_\_\_\_

Comments *(include any special medical or personal information you would want an emergency care provider to know)* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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: *(If same as above, leave blank)*

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

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

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

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

X \_\_\_ I have voluntarily provided the above contact information and authorize City of Hokah and its Representatives to contact any of the above on my behalf in the event of an emergency.

X \_\_\_ I choose not to furnish any emergency contact information to City of Hokah at this time.

Employee Name *(printed)* \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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**PLEASE DO NOT WRITE BELOW (FOR OFFICE USE ONLY)**

OFFICE NOTES:

Reviewed by: \_\_\_\_\_ Position: \_\_\_\_\_

Date: \_\_\_\_\_ Next Contact Update: \_\_\_\_\_