EMPLOYEE EMERGENCY CONTACT FORM

Name: ____

Department: ____

Home Address: ____

City, State, Zip: ____

Home Telephone #: ____________________ Cell #: ____________________

Emergency Contact Info:

Name: ______________________________Relationship: ______________

Address: ____

City, state, Zip: ____

Home Telephone #: __________________________ Cell #: __________

Work Telephone #: ______________________

Employer: ____

Name: ______________________________Relationship: ______________

Address: ____

City, State, Zip: ____

Home Telephone #: ____________________Cell #: ____________________

Work Telephone #: __________________________ Employer: ____________

Medical Contact Info:

Doctor Name: ____________________________Phone #: ______________

Dentist Name: ____________________________Phone #: ______________

☐ I have voluntarily provided the above contact information and authorize Family Support Organization of Essex County and its representatives to contact any of the above on my behalf in the event of an emergency.

Employee Signature: ______________________ Date: ____________

Employee Printed Name: ______________________

Revised: 2/26/2020