

Employee Emergency Care Plan

Full Name: _____

D.O.B: _____ Building/Position _____

Spouse's Name: _____

Home Address: _____

Home Phone: _____

Pager/Cell Phone: _____ Spouse's Pager/Cell Phone: _____

Spouse's Place of Employment: _____

Work Phone: _____ Department/ Extension: _____

Health Concerns / Allergies / Medication Allergies: _____

Medication taken regularly: _____

Doctor's Name: _____

Doctor's Phone: _____ Hospital preference: _____

List two people that can be contacted in case of an emergency if your spouse cannot be reached:

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

_____ Pager/Cell Phone _____

Place of Employment: _____ Phone Number: _____

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

_____ Pager/Cell Phone _____

Place of Employment: _____ Phone Number: _____