STAFF EMERGENCY INFORMATION

Please file this information sheet with the **District Office**

Date Completed: _____

NAME _____
Last First Middle/Maiden

SPOUSE _____
Last First Middle/Maiden

ADDRESS Street _____

City _____

Zip (9 digit) _____

PHONE # _(_____)_____ **CELL#** __(_____)_____

HOME E-MAIL #1 _____

HOME E-MAIL #2_____

DOCTOR _____ (_____)_____
First Middle Last Phone

CLINIC _____

HOSPITAL _____

Medical concerns or condition that may cause a problem (ie: Allergies, Medications, etc)_____

_____

List at least four people that could be contacted in case of an emergency. List in order of preference.

_____
Name Relationship Home Phone Work/Cell Phone

_____
Name Relationship Home Phone Work/Cell Phone

_____
Name Relationship Home Phone Work/Cell Phone

_____
Name Relationship Home Phone Work/Cell Phone