Accident/Emergency Procedure Card

☐ Updating ☐ No Change

SELECT ONE:
☐ Certificated
☐ Classified

EMPLOYEE NAME: _____ SS# _____
(PLEASE PRINT) LAST FIRST MIDDLE LAST 4-DIGITS

_____ _____ | _____
STREET ADDRESS CITY ZIP CODE HOME PHONE CELL PHONE

EMERGENCY CONTACTS - IN CASE OF ILLNESS OR INJURY (PLEASE PRINT)

1._____ | _____ | _____
SPOUSE (OR NEAREST RELATIVE) RELATIONSHIP HOME/ CELL PHONE

2._____ | _____ | _____
NAME RELATIONSHIP HOME/ CELL PHONE

3._____ | _____ | _____
NAME RELATIONSHIP HOME/ CELL PHONE

Primary Physician

_____
NAME PHONE

_____
INSURANCE PROVIDER GROUP #

_____
HOSPITAL PREFERENCE

List any physical condition(s) that could be significant in a medical emergency? (Include medication taken regularly, allergies, etc.)

_____

Do you give your permission to be transported by ambulance or other available means if necessary ☐ YES ☐ NO

_____
EMPLOYEE SIGNATURE **DATE** **WORK SITE/DEPARTMENT**

HR FORM | REVISION DATE: 8/4/2014 – EC