

**In Case of Emergency Form**

It is the responsibility of every employee to inform HR Department regarding any changes.

**I. GENERAL INFORMATION**

Employee Name: Vishal Srivastava

Gender:

M  F 

Date of Birth: 14-01-2000

Current Address: The Indian Home Pipe Co+Ltd  
Kauri Jhansi (U.P) 284003

City: Jhansi State: U.P

Permanent Address: The Indian Home Pipe Co+Ltd  
Kauri Jhansi (U.P) 284003

City: Jhansi State: U.P.

**Please provide your Family Details (Parents, Siblings, Spouse etc.)**

Name: Mr. Lokesh Lal Srivastava

Relationship: Father.

Phone: 9621666319

Address: The Indian Home Pipe Co+Ltd  
Kauri Jhansi (U.P) 284003

Name: Mrs. Uma Srivastava

Relationship: Mother

Phone: 7355565618

Address: The Indian Home Pipe Co+Ltd  
Kauri Jhansi (U.P) 284003.

Name:

Relationship:

Phone:

Address:

Name:

Relationship:

Phone:

Address:

Name:

Relationship:

Phone:

Address:

Name:

Relationship:

Phone:

Address:

Name:

Relationship:

Phone:

Address:

Name:

Relationship:

Phone:

Address:

**Please provide the details of any of your friends**

Name: <i>Sourabh Ovi</i>	Location: <i>Hydrabad</i>	Profession: <i>IT engineer</i>
Home Phone: <i>9618389189</i>	Work Phone:	Cellular Phone:
Name: <i>Samath</i>	Location: <i>New Delhi</i>	Profession: <i>Graphic Designer</i>
Home Phone:	Work Phone:	Cellular Phone:
Name:	Location:	Profession:
Home Phone:	Work Phone:	Cellular Phone:

**IN CASE OF EMERGENCY PLEASE CONTACT**

Name: <i>Lokesh Lal Saivastava</i>	Relationship: <i>Father</i>	
Home Phone: <i>9621666319</i>	Work Phone:	Cellular Phone: <i>93860 44310</i>
Name:	Relationship:	
Home Phone	Work Phone	Cellular Phone:

Preferred Hospital:

Physician's Name	Specialist Name:	Dentist Name:
Phone:	Phone:	Phone:

List all medications that you are taking (prescription and over the counter). If necessary include the reason of medication:

List allergies to medicine, food or other allergens, and any medical information such as physical impairments and assistive devices, that emergency personal need to be aware of, attach documentation is necessary:

**II. SIGNATURE AND CONSENT FOR EMERGENCY MEDICAL TREATMENT**

Employee Signature: <i>Nishaf</i>	Date Signed: <i>12-11-21</i>
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