

In Case of Emergency Form	It is the responsibility of every employee to inform HR Department regarding any changes.	
I. GENERAL INFORMATION		
Employee Name: ARUN KUMAR	Gender: M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Date of Birth: 20/09/2000
Current Address: Village- Akhtyanpur taga post-Tullupura District Sambhal (UP)		City: Sambhal State: UP
Permanent Address: Village- Akhtyanpur taga post-Tullupura District Sambhal		City: Sambhal State: UP
Please provide your Family Details (Parents, Siblings, Spouse etc.)		
Name: INDRA PAL SINGH	Relationship: Father	
Phone: 9756467275	Address: Village Akhtyanpur taga post-Tullupura District Sambhal	
Name: VIMLA DEVI	Relationship: Mother	
Phone: (06309) 7060507901	Address: Village- Akhtyanpur taga post Tullupura District Sambhal	
Name: ADARSH KUMAR	Relationship: younger Brother	
Phone: 8126086297	Address: Village- Akhtyanpur taga post Tullupura District Sambhal	
Name: AMAN KUMAR	Relationship: younger Brother	
Phone: 9045259506	Address: Village- Akhtyanpur taga post Tullupura District Sambhal	
Name: RINKU KUMAR	Relationship: cousin/ Elder brother	
Phone: 7906880000	Address: Village Akhtyanpur taga post Tullupura District Sambhal	
Name:	Relationship:	
Phone:	Address:	
Name:	Relationship:	
Phone:	Address:	
Name:	Relationship:	
Phone:	Address:	

Please provide the details of any of your friends

Name: RISHAV SHARMA	Location: PATWAI (RAMPUR)	Profession: Private Employee
Home Phone:	Work Phone:	Cellular Phone: 09544 91 724
Name: Amardeep Tyagi	Location: Rampur Urf Yanpur Sambhal	Profession: Private Employee
Home Phone: 9758146281	Work Phone:	Cellular Phone: 8630558945
Name:	Location:	Profession:
Home Phone:	Work Phone:	Cellular Phone:

IN CASE OF EMERGENCY PLEASE CONTACT

Name:	Relationship:	
Home Phone:	Work Phone:	Cellular Phone:
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:	Date Signed:
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