

Please provide the details of any of your friends		
Name:	Location:	Profession:
Home Phone:	Work Phone:	Cellular Phone:
Name:	Location:	Profession:
Home Phone:	Work Phone:	Cellular Phone:
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: 18/03/2026
		