

In Case of Emergency Form	It is the responsibility of every employee to inform HR Department regarding any changes.
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I. GENERAL INFORMATION

Employee Name: S.R. JAYARAJU	Gender: M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Date of Birth: 24-01-1992
Current Address: 1/89 J Abirami Nagar, Chinnampalayam, Kerala Samajam backside, Pollachi-642001, Tamil Nadu	City: Pollachi	State: Tamil Nadu
Permanent Address:	City:	State:

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

Name: R. S. RAJA	Relationship: Father
Phone: 9443822652	Address: 1/89 J. Abirami Nagar, Chinnampalayam Kerala Samajam backside, Pollachi-642001
Name: R. S. SUNDARI	Relationship: mother
Phone: 9442429652	Address: 1/89 J. Abirami Nagar, Chinnampalayam Kerala Samajam backside, Pollachi-642001
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>kathirvel</i>	Location: <i>chennai</i>	Profession: <i>student</i>
Home Phone:	Work Phone:	Cellular Phone: <i>98948 62728</i>
Name: <i>Groutham BABU</i>	Location: <i>Coimbatore</i>	Profession: <i>BUISSNESS</i>
Home Phone:	Work Phone:	Cellular Phone: <i>90036 68599</i>
Name:	Location:	Profession:
Home Phone:	Work Phone:	Cellular Phone:
IN CASE OF EMERGENCY PLEASE CONTACT		
Name: <i>R.S.Raja</i>	Relationship: <i>Father</i>	
Home Phone:	Work Phone:	Cellular Phone: <i>94438 22652</i>
Name: <i>kathirvel</i>	Relationship: <i>Friend</i>	
Home Phone:	Work Phone:	Cellular Phone: <i>98948 62728</i>
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>S.P. Janakap</i>		Date Signed: <i>23-02-2017</i>

Medical Insurance Nominee Form

Name:	S. R. JAYARAJU
ICICI Account No.(if you have)	
Pan card No:	AWNP 04654L
Your Date of Birth:	24 - 01 - 1992
Nominee:	R. S. RAJA.
Relationship with nominee:	Father
Marital Status (Single/Married):	Married.
If married please mention the below mentioned details:	
Wife/Husband's Name:	R. S. bundari
Date of Birth:	25 - 06 - 1966
Age:	50
Gender:	Female.
Child1's Name:	
Date of Birth:	
Age:	
Gender:	
Child2's Name:	
Date of Birth:	
Age:	
Gender:	