

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

Employee Name: <i>Jayashree Manohar Chavan</i>	Gender: M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Date of Birth: <i>08-08-1999</i>
Current Address: <i>Runwal mycity, Diva manpada Road, Dombivali East 400612</i>	City: <i>Mumbai</i>	State: <i>Maharashtra</i>
Permanent Address: <i>2201/A-4 Polaris Runwal mycity, Diva manpada Road, Dombivali East</i>	City: <i>Mumbai</i>	State: <i>Maharashtra</i>

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

Name: <i>MANOHAR SITARAM CHAVAN</i>	Relationship: <i>Father</i>
Phone: <i>9920091530</i>	Address: <i>Runwal mycity, Diva manpada Road, Dombivali East - 400612</i>
Name: <i>MANISHA MANOHAR CHAVAN</i>	Relationship: <i>Mother</i>
Phone: <i>9082054435</i>	Address: <i>Runwal mycity, Diva manpada Road, Dombivali East - 400612</i>
Name: <i>VAIBHAV MANOHAR CHAVAN</i>	Relationship: <i>Brother</i>
Phone: <i>8291718061</i>	Address: <i>2201-A4-Polaris Runwal mycity Diva manpada road, Dombivali - 400612</i>
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:	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: <i>[Signature]</i>		Date Signed: 24-02-2026