EMPLOYEE EMERGENCY INFORMATION

Submit form to office / unit timekeeper promptly upon being hired by the department and/or whenever there are changes in information previously submitted. A copy will be kept on file in Human Resources.

If you have a chronic medical problem (i.e., heart condition, epilepsy, asthma, allergy, etc.) that could incapacitate you during working hours, you are encouraged to discuss symptoms and emergency treatment with each of your supervisors and first aiders in your area during your employment with this department.

EMPLOYEE NAME (Last, First, Middle Initial)	HOME PHONE NUMBER
HOME ADDRESS (Street Number and Name, City, State, Zip Code) **NO P.O. BOXES**	CELL PHONE NUMBER
PERSONAL EMAIL:	WORK PHONE NUMBER

PERSONS TO NOTIFY IN CASE OF EMERGENCY

NAME (Last, First)	RELATIONSHIP		HOME PHONE NUMBER
ADDRESS (Street Number and Name) **NO P.O. BOXES**			WORK PHONE NUMBER
CITY	STATE	ZIP CODE	CELL PHONE NUMBER
NAME (Last, First)	RELATIONSHIP		HOME PHONE NUMBER
ADDRESS (Street Number and Name) **NO P.O. BOXES**			WORK PHONE NUMBER
CITY	STATE	ZIP CODE	CELL PHONE NUMBER

PHYSICIAN DESIGNATION

☐ I do not wish to designate a personal physician / chiropractor* in case of a work related or non-work related injury or sudden illness and will accept medical treatment from the department's designated medical facility.

☐ I request the services of my primary personal physician / chiropractor* in the case of a work related or non-work related injury or illness. (MUST be agreed upon and signed by your primary physician / chiropractor. If form is not signed and returned, the physician / chiropractor will not be considered predesignated.)

* Personal physician / chiropractor for the purpose of treating a work injury is defined in Section 4600 of the Labor Code as the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code who has previously directed the medical treatment of the employee and who retains the employee's medical records, including the employee's medical history and agrees to be predesignated.

PHYSICIAN'S NAME (Last, First, Middle Initial)

OFFICE ADDRESS (Street Number and Name, City, State, Zip Code)	OFFICE PHONE NUMBER
PHYSICIAN'S SIGNATURE	DATE SIGNED
EMPLOYEE'S SIGNATURE	DATE SIGNED