

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
IN THE EVENT OF AN ARREST OR DETENTION		
<input type="checkbox"/> I request that in the event of an arrest or detention at work, the person below be contacted.		
NAME	PHONE NUMBER	

* California Labor Code 1555, added by SB294, imposes the new obligation that California employers notify an employee's designated emergency contact in the event the employee is arrested or detained at the worksite or offsite during work hours if the employer has actual knowledge of the arrest or detention.

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 pre-designated.)

* 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 pre-designated.

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