Employee Health and Emergency Contact Form

Employee Name: _____

Address: _____

Home Phone: _____ Alt. Phone: _____

In the event of a medical emergency, are there any emergency procedures, information concerning medications or restrictions on medications, of which we or the emergency personnel should be aware? If yes, please list below:

_____
_____
_____
_____

Please notify in case of emergency:

Primary Contact

Name: _____

Address: _____

Phone: _____

Secondary Contact

Name: _____

Address: _____

Phone: _____

Physician

Name: _____

Address: _____

Phone: _____

Employee Authorization:

I have voluntarily provided the above contact information and authorize Allied Physical Therapy and its representatives to contact any of the above individuals on my behalf in the event of any emergency.

_____ _____

Employee Signature Date