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| **Employee Emergency Contact Sheet*****About this form:*** The information provided on this form will be used in an emergency only, to notify specified individual(s) of a serious illness, injury, or incident. This information will remain confidential.*Submit a new form if this information changes.* *Email to* *deshr@des.wa.gov* *or send a paper copy to Mailstop 41407.* |
| **EMPLOYEE INFORMATION**  |

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| **Name:** | **Personnel #:** | **Division:** |
| **Home Address:** | **City:** | **State/Zip:** |
| **Home Phone #:** | **Cell Phone #:**  |
| **EMERGENCY CONTACT INFORMATION** (list in the order to be contacted) |
| **1st Emergency Contact** |
| **Name:** | **Relationship:** |
| **Home Phone #:** | **Cell Phone #:** |
| **Address:** | **City, State, Zip:** |
| **2nd Emergency Contact** |
| **Name:** | **Relationship:** |
| **Home Phone #:** | **Cell Phone #:** |
| **Address:** | **City, State, Zip:** |
| **3rd Emergency Contact** |
| **Name:** | **Relationship:** |
| **Home Phone #:** | **Cell Phone #:** |
| **Address:** | **City, State, Zip:** |

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| **Date Signed** | **Employee’s Signature** |
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If you choose to provide additional medical information, please complete the back side of this form.

This medical information will be accessible in a medical or potentially life-threatening EMERGENCY ONLY, to notify paramedics/emergency response, and/or specified individual(s).

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| **Additional Information (voluntary)** |
| **Please list any health considerations or any information you would like an emergency care provider to know in case of emergency (food/drug/insect allergies, current medications, diabetes, epilepsy, etc.)** |
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