EMERGENCY NOTIFICATION INFORMATION

Agency:_____ Date:_____

EMPLOYEE INFORMATION

* LAST NAME	* FIRST	M.I.
* ADDRESS		
* CITY	* STATE	* ZIP CODE
* HOME PHONE	Cell Number	Date of Birth

PRIMARY NEXT-OF-KIN NOTIFICATION

* RELATIONSHIP		
* LAST NAME	* FIRST	* RELATIONSHIP
* ADDRESS (NOT POST OFFICE BOX)		
* CITY	STATE	
* PRIMARY PHONE NUMBER	* SECONDARY PHONE NUMBER	
PRIMARY NEXT-OF-KIN's PLACE OF WORK		PHONE NUMBER AT WORK
ADDRESS		
CITY	STATE	

CHILDREN (optional)

LAST NAME	FIRST	PHONE NUMBER
ADDRESS		
CITY	STATE	
LAST NAME	FIRST	
ADDRESS		
CITY	STATE	
ANY KNOWN MEDICAL CONDITIONS TO BE ADVISED OF WHEN MAKING ANY NOTIFICATION TO THE NEXT-OF-KIN?		
WHO WOULD YOU LIKE TO MAKE A NOTIFICATION OF MAJOR INJURY OR DEATH TO YOUR NEXT-OF-KIN?	PHONE NUMBER TO REACH THIS PERSON?	

* Indicates those items that would be most helpful to the Agency.

SECONDARY NEXT-OF-KIN NOTIFICATION

PLEASE INDICATE A SECOND NEXT-OF-KIN WHOM YOU WOULD TO BE NOTIFED AFTER THE PRIMARY NEXT-OF-KIN HAS BEEN NOTIFIED?

WHOM WOULD YOU LIKE TO MAKE THIS NOTIFICATION?	PHONE NUMBER
NAME (SECONDARY NEXT-OF-KIN)	PHONE NUMBER

ADDRESS (NOT A POST OFFICE BOX)

CITY STATE

MEDICAL (Optional Information)

* IN THE EVENT OF A MAJOR INJURY, AND YOU ARE UNCONSICOUS WHAT ARE YOUR WISHES REGARDING LIFE SUPPORT SERVICES?

* WHO HAS RIGHTS TO CARRY OUT YOUR WISHES REGARDING LIFE SUPPORT SERVICES?

NAME OF PHYSICIAN TO BE NOTIFIED (Optional) AND PHONE NUMBER/HOSPITAL

* WHAT ARE YOUR WISHES REGARDING BLOOD TRANSFUSIONS?	YOUR BLOOD TYPE?

NAME OF CLERGY, PRIEST, MINISTER, TO BE NOTIFIED ***(OPTIONAL)***

DENOMINATION (OPTIONAL) *Medical Plan, Group # ,Subscriber #, Plan & Phone#

ARE THERE ANY PEOPLE WHO YOU WOULD **NOT** LIKE NOTIFIED IN CASE OF MAJOR INJURY OR DEATH?

ANNUAL VERIFICATION SECTION: Initial and Date that information has been updated/verified:
(should be done when information changes and/or at performance evaluations)

Instructions

Supervisor: This form should be made available to employees and completed upon hiring and updated at performance evaluations or at least annually. Inform employees that use of this form is not mandatory, but is necessary in the event that an emergency occurs. If they choose to have emergency data on file, check the entries carefully to determine they are complete and understandable. This may be your only source of information in case of an emergency. Completed forms should be kept in the Emergency Contact Notification binder in the locked personnel cabinets.

Employee: If you choose to have emergency data on file, complete this form when you enter on duty and give it to your work Supervisor or personnel staff. It is your responsibility to update the entries when there is a change in information. All information on this form is requested on a voluntary basis under the authority of Title 5 U.S. C. 301,7CFR 6.60. It will be used only in the event of an emergency.

I have read and understood the above instructions. I understand that I may elect not to use this form or leave sections intentionally blank but that doing so, may delay emergency services/notifications that would be otherwise available.

Employee Signature:_____ Date:_____