UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

EMERGENCY CONTACT AND MEDICAL INFORMATION

PLEASE TYPE OR PRINT CLEARLY WHEN COMPLETING THIS INFORMATION

CURRENT ADDRESS

EMPLOYEE NAME		DATE OF BIRTH
STREET ADDRESS		APARTMENT NUMBER
CITY	STATE	ZIP CODE
HOME TELEPHONE	WORK TELEPHONE	EXTENSION OR DEPARTMENT
OPTIONAL: CELL PHONE NUMBER	OPTIONAL: PERSONAL E-MAIL ADDRESS(S) (TO BE USED IN AN EMERGENCY)	

LIST ANY MEDICAL INFORMATION (INCLUDING ALLERGIES OR DISABILITIES) WHICH MAY ASSIST US IN THE EVENT OF AN EMERGENCY:

_____

_____

EMERGENCY CONTACT

PLEASE MAKE SURE THAT THE PERSON TO BE NOTIFIED IN CASE OF AN EMERGENCY MAY BE REACHED DURING **REGULAR BUSINESS HOURS**. IF THE PERSON IS REGULARLY EMPLOYED, PLEASE PROVIDE A WORK TELEPHONE NUMBER AS WELL AS A HOME TELEPHONE NUMBER.

NAME		RELATIONSHIP
STREET ADDRESS		APARTMENT NUMBER
CITY	STATE	ZIP CODE
HOME TELEPHONE	WORK TELEPHONE	EXTENSION OR DEPARTMENT

OUT OF STATE CONTACT

NAME		RELATIONSHIP
STREET ADDRESS		APARTMENT NUMBER
CITY	STATE	ZIP CODE
HOME TELEPHONE	WORK TELEPHONE	EXTENSION OR DEPARTMENT

PHYSICIAN INFORMATION

NAME		TELEPHONE NUMBER
STREET ADDRESS		SUITE
CITY	STATE	ZIP CODE

_____ _____

Date Signed *Signature of Employee*