HRST, Inc.

MEDICAL EMERGENCY NOTIFICATION FORM

NAME: _____

DEPARTMENT/OFFICE: _____

PERSON(S) TO CONTACT IN AN EMERGENCY: (Please provide at least 2 contacts)

Name	Relationship	Cell #
Name	Relationship	Cell #
Name	Relationship	Cell #

NAME OF DOCTOR OR CLINIC TO BE CALLED IN AN EMERGENCY:

Doctor

Clinic

Address

Telephone #

Please advise of any existing or ongoing medical condition known to you, allergies known to you and if relevant, any medication currently or regularly being used that may prohibit certain treatment in a medical emergency or that may cause a medical emergency under certain conditions. Again, this is voluntary and confidential information.

Signature of Employee Date