

## VOLUNTEER EMERGENCY CONTACT FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

In the event of an emergency, please list the names and telephone numbers of two individuals you would like us to contact:

**Emergency Contact #1:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

**Emergency Contact #2:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Do you give us permission to transport you to the nearest medical facility should you incur serious illness or injury during normal work hours?

Yes  No

If yes, please indicate the name and contact telephone number of the physician or health care provider that you would like for us to contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_