ASSOCIATED STUDENTS
SAN DIEGO STATE UNIVERSITY

EMPLOYEE EMERGENCY INFORMATION

Employee Name: _____ Red ID #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ E-mail Address: _____

Cell Phone Number: _____ Work Phone Number: _____

Date of Birth: _____Date of Hire: _____

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Home Phone Number: _____ Cell Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

IF UNABLE TO REACH ABOVE NOTIFY:

Name: _____ Relationship: _____

Home Phone Number: _____ Cell Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Date form completed/updated: (To be verified or updated bi-annually) _____

Unusual Medical Conditions:

Please List Medicine/Substance Allergies:

NOTICE TO EMPLOYEES: In the event of an emergency or disaster, transportation and availability to medical service may be delayed. It is recommended that any required health sustaining medication be in your possession. A minimum three (3) day supply is recommended.

Employee's Signature _____ Date: _____