SSD-014

EMERGENCY CONTACT & MEDICAL INFORMATION FORM

Support timely emergency communication and care. Protect sensitive information and keep records current.

2 Project Information		**Form / Record No.**	
Project / Jobsite Location		**Form Date / Updated**	
1 Company Information		**Employee Work Shift**	☐ Day ☐ Night ☐ Other: _____
5 Job Title		**6 Date of Hire**	
3 Employee Information		**21 Supervisor Verification**	

1–6 Company, Project, and Employee Information

Complete required identification fields; optional medical fields may be left blank.

7 Primary Emergency Contact	8 Secondary Emergency Contact
Name: _____ Relationship: _____ Mobile phone: _____ Home phone: _____ Work phone: _____ Email / notes: _____	Name: _____ Relationship: _____ Mobile phone: _____ Home phone: _____ Work phone: _____ Email / notes: _____ Contact priority / availability: _____ ☐ Other: _____

7–8 Emergency Contacts

Provide current contacts authorized to be notified in an emergency.

INFORMATION	**9 Home Address**	**10 Blood Type (Optional)**	**11 Allergies (Optional)**	**12 Medical Conditions (Optional)**	**13 Current Medications (Optional)**
CARE CONTACT	**14 Primary Care Physician**	**15 Preferred Hospital**	**16 Health Insurance**	**17 Claim Information**	**Emergency Notes**

Contact priority: PRIMARY SECONDARY ALTERNATE UPDATE REQUIRED

Privacy rule: Collect only information authorized and needed for legitimate emergency, benefits, or claim purposes. Limit access, store securely, and follow applicable privacy, retention, and disclosure requirements.

9–16 Medical and Care Information

Optional medical disclosures should be limited to information relevant to emergency response.

#	ITEM	INFORMATION / DETAILS	EMERGENCY INSTRUCTIONS / NOTES	OPTIONAL	UPDATED	VERIFIED BY
1						
2						
3						
4						
5						
6						
7						

Optional means the employee may leave the field blank unless another lawful requirement applies.

Information reminder: Review entries for accuracy, identify any communication or access needs, update changes promptly, and avoid placing sensitive medical details in general-access files or posting this form publicly.

17–18 Insurance and Claim Information

9–13 Personal and Medical Information	14–16 Physician, Hospital, and Insurance
9 Home Address: _____ City / State / ZIP: _____ 10 Blood Type (Optional): _____ 11 Allergies (Optional): _____ Reaction / emergency response: _____ 12 Medical Conditions (Optional): _____ Emergency considerations: _____ 13 Current Medications (Optional): _____ Dosage / schedule (Optional): _____ Communication / accessibility needs: _____ Additional emergency notes: _____ Last updated: _____ ☐ Other: _____	14 Primary Care Physician: _____ Physician phone: _____ 15 Preferred Hospital: _____ Hospital address / phone: _____ 16 Health Insurance Information (Optional) Carrier / plan: _____ Member / policy ID: _____ Group no.: _____ Insurance phone: _____ Card copy provided: ☐ Yes ☐ No Benefits contact: _____ Other: _____ ☐ Other: _____

19 Authorization for Emergency Medical Treatment

Emergency Services / Site Contact		**15 Preferred Hospital**	
Emergency Meeting / Pickup Point		**Project Address / Coordinates**	
19 Emergency Treatment Authorization	☐ Authorized ☐ Limited / instructions attached	**Special Emergency Instructions**	Details: _____
First Aid / AED Location		**Emergency Notification Method**	☐ Radio ☐ Phone ☐ Verbal ☐ Other: _____

20 Employee Acknowledgement

☐ Employee information reviewed	☐ Emergency contacts reviewed	☐ Optional medical fields identified	☐ Treatment authorization selected
☐ Privacy notice reviewed	☐ Employee questions answered	☐ Updates / attachments received	☐ Other: _____

Confidentiality and Update Notice

Update this form when emergency contacts, address, physician, hospital preference, insurance, medications, allergies, or relevant medical

information changes. Submit updates through the designated confidential process. Do not email, post, or leave completed forms where unauthorized persons may view them.

HR Update / Access Log No.		**Date / Time**	
Administrative Update / Authorized Disclosure		**HR / Authorized Custodian**	

20–22 Acknowledgement and Verification *Signatures confirm review, not a waiver of employee rights.*

ACKNOWLEDGEMENT / VERIFICATION	PRINTED NAME	SIGNATURE	DATE
20 Employee Acknowledgement			
21 Supervisor Verification			
22 HR Use Only			
Authorized Privacy / Benefits Review			

HR Confidential Review / Updates: Record authorized administrative follow-up only.

I confirm that the information I chose to provide is accurate to the best of my knowledge; understand optional fields may be left blank; authorize use and disclosure only as permitted for emergency response, benefits, claims, or other lawful purposes; and will submit updates when information changes.

UPDATE / AUTHORIZED USE	AUTHORIZED PERSON	PURPOSE / REFERENCE	DATE / COMPLETED

20 Employee Acknowledgement | 21 Supervisor Verification | 22 HR Use Only / Record Retention

Employee Review	☐ Complete ☐ Update requested	**Date / Time**	
Supervisor Verification	☐ Identity / fields reviewed ☐ Sent to HR	**22 HR Use Only / Confidential Notes**	
22 Record Retention Location / Period		**Record Filed / Custodian**	

IMPORTANT: This form supports emergency communication and administrative readiness but is not medical advice, an advance directive, or a guarantee of treatment. Follow emergency protocols first. Store and disclose completed forms only as authorized, and follow applicable privacy, benefits, workers' compensation, and record-retention requirements.