New Jersey Department of Health

EMERGENCY MEDICAL INFORMATION

All employees are required to complete Section I and II of this form. As indicated, completion of Section III is voluntary. Return the completed form to your division administrative offices. A copy will be kept at the employee's official work location, division personnel file and the Human Resources Services office. ***All information is confidential.***

SECTION I			
Name of Employee			Date
Street Address			
City, State, Zip Code			Telephone Number
SECTION II – EMERGENCY CONTACTS			
1	Name		Relationship
	Street Address		
	City, State, Zip Code		Telephone Number
	Home Telephone Number	Work Telephone Number	Mobile Telephone Number
2	Name		Relationship
	Street Address		
	City, State, Zip Code		Telephone Number
	Home Telephone Number	Work Telephone Number	Mobile Telephone Number
SECTION III – CONTACT FOR MEDICAL ASSISTANCE (VOLUNTARY)			
Name of Physician or Health Group			Medical ID Number
Street Address			
City, State, Zip Code			Telephone Number
Allergies to Medication			Blood Type, If Known

Copies to: Official Work Location
Division Office
Human Resources Services