Kansas State School for the Blind
Employee Emergency Contact Form

Employee Name:_____
Last First M.I.

Spouse's Name:_____

Home Address: _____
Street Address

_____ _____ _____
City State ZIP Code

Phone: _____
(home) (work) (other – cellular)

In Case of Emergency: (*Please list two people that may be contacted*)

Name: _____ (Relationship:)**

Address: _____
Street City State ZIP Code

Phone: _____
(home) (work) (other – cellular)

Name: _____ (Relationship:)**

Address: _____
Street City State ZIP Code

Phone: _____
(home) (work) (other - cellular)

Physician: _____

Phone: _____

Hospital: _____

Vehicle Information:

Year: _____ Make: _____ Model: _____

Vehicle License Number: _____

Driver's License Number: _____ State: _____

** (Relationship: example Friend, Sister, Mother, Son, etc) *Relationship is not mandatory*

DATE COMPLETED:_____