KINGSBOROUGH COMMUNITY COLLEGE
The City University of New York
EMERGENCY CONTACT INFORMATION

NAME OF EMPLOYEE: _____

TITLE: _____

DEPARTMENT: _____

If possible, complete information in the spaces provided below for at least two Emergency Contacts. (Please print legibly.)

Emergency Contact #1

Name: _____ Relationship: _____

Address: _____
Number Street City State Zip Code

Home Phone: _____ Business Phone: _____

Emergency Contact #2

Name: _____ Relationship: _____

Address: _____
Number Street City State Zip Code

Home Phone: _____ Business Phone: _____

Emergency Contact # 3

Name: _____ Relationship: _____

Address: _____
Number Street City State Zip Code

Home Phone: _____ Business Phone: _____

Please be advised that completion of the "Medical Information" section indicated below is entirely discretionary. (Please print legibly.)

MEDICAL INFORMATION

PERSONAL PHYSICIAN: _____

PHYSICIAN'S PHONE: _____

BLOOD TYPE: _____

OTHER MEDICAL INFO: _____

_____ _____

Employee's Signature Date