GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Emergency Information

Date:

Employee Name:	**Social Security #:**	**Date of Birth:**	
Address:	**City:**	**State:**	**Zip:**
County:	**E-mail Address:**		
Home Phone:	**Work Phone:**	**Cell Phone:**	

Emergency Contact Information

Primary Contact Name:		**Relationship:**	
Address:	**City:**	**State:**	**Zip:**
County:	**E-mail Address:**		
Home Phone:	**Work Phone:**	**Cell Phone:**	

Secondary Contact Name:		**Relationship:**	
Address:	**City:**	**State:**	**Zip:**
County:	**E-mail Address:**		
Home Phone:	**Work Phone:**	**Cell Phone:**	

Statistical Information

Gender: ☐ **Male** ☐ **Female**	**Marital Status: (Optional)** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**
Veteran: ☐ **Yes** ☐ **No**	**Ethnic Group:** ☐ **American Indian** ☐ **Asian** ☐ **African American** ☐ **Hispanic** ☐ **Caucasian** ☐ **Multi-Racial**

Print Form

See the Possibilities