STATE OF CALIFORNIA

EMERGENCY NOTIFICATION INFORMATION

CDCR 894 (Rev. 09/19)

Employees are responsible for ensuring this form is updated when changes occur. The person(s) to be notified in case of emergency should be over the age of 18.

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE):		**LAST 4 DIGITS OF SOCIAL SECURITY NUMBER (FOR ID PURPOSES ONLY):**
HOME ADDRESS (STREET NUMBER AND NAME, CITY, STATE, AND ZIP CODE):		
HOME PHONE NUMBER:	**WORK PHONE NUMBER:**	**CELL PHONE NUMBER:**
INSTITUTION/FACILITY/PROGRAM AREA AND UNIT:	**PERSONAL EMAIL ADDRESS:**	

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY (over the age of 18)

NAME (LAST, FIRST, MIDDLE):		**RELATIONSHIP:**
HOME ADDRESS (STREET NUMBER AND NAME, CITY, STATE, AND ZIP CODE):		
HOME PHONE NUMBER:	**WORK PHONE NUMBER:**	**CELL PHONE NUMBER:**

ALTERNATE PERSON TO BE NOTIFIED IN CASE OF EMERGENCY (over the age of 18)

NAME (LAST, FIRST, MIDDLE):		**RELATIONSHIP:**
HOME ADDRESS (STREET NUMBER AND NAME, CITY, STATE, AND ZIP CODE):		
HOME PHONE NUMBER:	**WORK PHONE NUMBER:**	**CELL PHONE NUMBER:**

MEDICAL INFORMATION

PERSONAL PHYSICIAN'S NAME:		**PHONE NUMBER:**
MEDICAL PLAN NAME:	**MEDICAL PLAN CARD NUMBER:**	**MEDICAL FACILITY NAME AND LOCATION:**
SPECIAL MEDICAL CONDITIONS (ALLERGIES, ETC.):		
SPECIAL INSTRUCTIONS:		
EMPLOYEE'S SIGNATURE:		**DATE:**

This information will be kept confidential and used for emergencies only. This form will be filed in your Official Personnel File (OPF) and in the supervisory file.

PERSONNEL OFFICE USE	
REVIEWER'S PRINTED NAME:	
BIS KEY DATE:	**PHONE NO.:**

DISTRIBUTION **Original:** OPF **Copy:** Supervisor File