STATE OF CALIFORNIA

EMERGENCY NOTIFICATION INFORMATION

CDC 894 (9/92)

2 Part Form---Must be submitted in duplicate.

DEPARTMENT OF CORRECTIONS

DIST:
ORIG - OFFICIAL PERSONNEL FILE
COPY - EMPLOYEE'S SUPERVISOR

THIS INFORMATION WILL BE KEPT CONFIDENTIAL IN YOUR OFFICIAL PERSONNEL FILE AND YOUR SUPERVISOR'S EMPLOYEE RECORDS AND WILL BE USED FOR EMERGENCIES ONLY. PLEASE BE SURE TO UPDATE THIS INFORMATION SHOULD IT CHANGE.

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER (PROVISION IS VOLUNTARY. REQUESTED FOR ID PURPOSES ONLY)
HOME ADDRESS: (STREET NUMBER AND NAME, CITY AND ZIP CODE)	HOME TELEPHONE NUMBER
EMPLOYED (FACILITY AND UNIT)	WORK PHONE NUMBER

PLEASE INDICATE PERSON(S) TO BE NOTIFIED IN CASE OF EMERGENCY

NAME		RELATIONSHIP	
ADDRESS	HOME TELEPHONE NUMBER		WORK TELEPHONE NUMBER
NAME		RELATIONSHIP	
ADDRESS	HOME TELEPHONE NUMBER		WORK TELEPHONE NUMBER

MEDICAL INFORMATION

PERSONAL PHYSICIAN'S NAME	TELEPHONE NUMBER
MEDICAL PLAN NAME AND CARD NUMBER (IF APPLICABLE)	MEDICAL FACILITY'S EMERGENCY PHONE NUMBER

SPECIAL MEDICAL CONDITIONS (ALLERGIES, ETC.)

SPECIAL INSTRUCTIONS (IF APPLICABLE)

EMPLOYEE'S SIGNATURE	DATE