MEDICAL/EMERGENCY NOTIFICATION

PLEASE FILL OUT COMPLETELY PRIOR TO THE FIRST DAY OF CLASS

NAME ______________________________ DATE ____________

TITLE ______________________________ WORK PHONE ____________

DEPARTMENT ______________________________

ADDRESS ______________________________
(STREET) (CITY) (ZIP CODE)

SUPERVISOR'S NAME/TITLE ______________________________ WORK PHONE ____________

RESIDENCE WHILE ATTENDING COURSE ______________________________ PHONE ____________
(HOTEL)

ADDRESS ______________________________
(STREET) (CITY) (ZIP CODE)

WORKERS COMPENSATION INSURANCE CARRIER ______________________________

POLICY NUMBER ______________________________ PHONE ____________

PERSONAL PHYSICIAN ______________________________ PHONE ____________

ADDRESS ______________________________
(STREET) (CITY) (ZIP CODE)

EMERGENCY NOTIFICATION

IN THE EVENT OF DEATH, INJURY, OR SUDDEN ILLNESS WHILE IN CLASS, I HEREBY REQUEST PERSONNEL OF THE DEPARTMENT OF JUSTICE TO NOTIFY THE PERSON(S) LISTED BELOW.

NAME ______________________________
RELATIONSHIP DAY PHONE HOME PHONE

NAME ______________________________
RELATIONSHIP DAY PHONE HOME PHONE

OTHER IMPORTANT MEDICAL INFORMATION

STUDENT'S SIGNATURE ______________________________ DATE ____________