EMERGENCY CONTACT INFORMATION
In Case of Accident or Death

Proponent is the Directorate for State Human Resources Management (MNHS)

By completing this form you are telling MNHS who to contact should you suffer an injury or illness while at work. This information will be used ONLY in an emergency or as may be required by law under extraordinary circumstances. This form should be completed and returned via email or in a sealed envelope to MNHS, ATTN: Mrs. Tina Lehning, to be placed in your personal history folder. Should any of this information change, please submit a corrected form to MNHS. It is important that this data be kept current at all times. This form is also located on the MNHS website at http://dmna.ny.gov. This form is also available in the DMNA Electronic Library.

EMPLOYEE NAME: _____ DATE: _____

Emergency Contacts (please provide at least 2 contacts):

Primary Contact:

NAME: _____

RELATIONSHIP: _____

PRIMARY PHONE (HOME☐ CELL☐): _____

WORK PHONE: _____

Email (optional): _____

Secondary Contact:

NAME: _____

RELATIONSHIP: _____

PRIMARY PHONE (HOME☐ CELL☐): _____

WORK PHONE: _____

Email (optional): _____

PLEASE COMPLETE AND RETURN TO MNHS

Provisions of the Privacy Act of 1974, the New York State Personal Privacy Protection Law and Health Insurance Portability and Accountability Act (HIPAA) apply to this form when you furnish your personal information. This information will be maintained by the State Human Resources Management Office.