

# Personal Data Sheet

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_

Home Email \_\_\_\_\_

Date of Birth \_\_\_\_\_

In the event of an emergency, please contact:

Name \_\_\_\_\_

Relationship to Employee \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_

Work Telephone (\_\_\_\_) \_\_\_\_\_

Personal Physician \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Specialist \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Medications \_\_\_\_\_

Allergies \_\_\_\_\_

COVID Vaccination Status (circle one):

Fully Vaccinated      Partially Vaccinated      Not Vaccinated      Prefer Not to Answer

If fully vaccinated, please provide a copy of your vaccination card to the main office.

Motor Vehicle Information:

Year \_\_\_\_\_ Make & Model \_\_\_\_\_ License # \_\_\_\_\_

Please provide us with any medical information that you feel pertinent:

\_\_\_\_\_