EMERGENCY INFORMATION

State Privacy Notification

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principle purpose for requesting the information on this form is to facilitate appropriate action by your department in the event of an emergency circumstance involving yourself. University policy and State statutes authorize maintenance of this information.

Furnishing any or all information on this form in voluntary. Information on this form may only be transmitted to other individuals who are deemed appropriate in connection with a health or safety emergency; and will be transmitted to the State and Federal governments if required by law.

Individuals have the right to review their own records in accordance with Staff Personnel Policy 605 and Academic Personnel Manual Section 195. Information on these policies can be obtained from campus or Systemwide Staff and Academic Personnel Offices.

The official(s) responsible for maintaining the information contained on this form is (are):

Center for Health and the Environment	Diane Kruger
Office	Department Head and or Designee

Name ____________ ________________________________ Date ________________

Telephone # ________________ Mobile # ________________ Email Address ______________________________

Address ____ City ________________ State _____ Zip __________

Vehicle Info: Make: ____________ Model ____________ Color ____________ Year _____ License _________

Graduate Students please fill out this section

Graduate Group ______________________________ Faculty/Lab ______________________________

Degree Earned ______________________________ Degree Pursued ______________________________

Home Country ______________________________

Please indicate the person or persons to be contacted in case of severe illness, accident or other emergency circumstance

Name ____ Relationship ______________________

Address ____

City ______________________ State ______________ Zip Code ______________________

Telephone (_____)________________________ Work Telephone (_____)________________________

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Name ____ Relationship ______________________

Address ____

City ______________________ State ______________ Zip Code ______________________

Telephone (_____)________________________ Work Telephone (_____)________________________

Physician and Health Care Information

Physician ________________________________ Telephone (_____)________________________

Address ____

City ______________________ State ______________ Zip Code ______________________

Name of Health Insurance Carrier ____

ID#______________ Group or Account # ____________________ Coverage ______________________