

Disclaimer: This form is strictly voluntary! Please complete ONLY if you would like Management to act in a specific way in case a medical emergency occur. You, by no means, are obligated to inform Management of any medical conditions. The Association holds no liability for inability to perform these actions properly or timely.

Name: \_\_\_\_\_ Unit #: \_\_\_\_\_

Please describe medical condition, including warning signs & symptoms:

What steps would you like for our Staff to take in case of medical emergency?

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

❖ Signature: \_\_\_\_\_ Date: \_\_\_\_\_