

NAME (Last name first)

Department

CITY OF SANTA CLARA
VOLUNTEER MEDICAL INFORMATION

Last name	First name	Home Phone	
Address	City	Zip code	
Designated Physician for job related injuries & illness	Address	Phone No.	
Hospital preference	Address	Phone No.	
Dentist preference	Address	Phone No.	
Volunteer's Health Plan	Group & member no.	Blood type	Date of Birth

List below brief medical history including previous operations, broken bones, allergies, diseases, etc.

Emergency Contact Information

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP
1.			
2.			
3.			

In case of emergency, I hereby give my permission to the City of Santa Clara to release any and all information contained on this card as may be necessary for my care and well being.

Volunteer's signature

Date

The following is to be signed ONLY if you have designated a personal physician. *

I understand that initial medical treatment for illness and injuries for "first aid" or "emergency treatment," as provided for in CMD #112, will be at a City designated medical facility.

Volunteer's signature

Date

- You may designate only ONE physician of your choice. It must be a physician who has treated you previously and has your medical records. The physicians' office must be located within a 7-1/2 air mile radius of City Hall. If you leave this section blank, you will be treated by a City designated medical facility.

In the case of the Kaiser Health plan only, you may designate Kaiser Hospital as the "designated physician" without naming an individual physician.