Reset Form

CALIFORNIA STATE UNIVERSITY, FRESNO
AUXILIARY CORPORATIONS

EMPLOYEE EMERGENCY INFORMATION

Please complete the following emergency information (please print):

Employee Name _____ Phone _____

Address _____ Cell _____

City _____ Zip _____

In case of emergency, notify the following:

Name _____ Relationship _____

Address _____ Phone _____

City _____ Zip _____ Work _____

PRE-DESIGNATE PHYSICIAN FOR WORK RELATED INJURY

Please read carefully: This information pertains to work-related injury or illness:

You are entitled to be treated by your own personal physician if the pre-designation form is completed and returned to the Auxiliary Human Resources Office prior to any work-related injury. If you do not pre-designate a physician and need medical treatment for a work-related injury or illness, you will be referred to the organization's approved physician.

Please complete below:

☐ I elect to be treated by the organizations' approved work physician

☐ I elect to be treated by my own physician (Please list physician information below)

_____ _____
Physician Name Phone

_____
Address City Zip Code

Employee Signature _____ Date _____