STATE OF CALIFORNIA
DEPARTMENT OF FORESTRY AND FIRE PROTECTION

EMERGENCY NOTIFICATION INFORMATION

CAL FIRE-31 (Rev. 10/04)

PRINT CLEAR FORM

THE INFORMATION PRACTICES ACT OF 1977 (CIVIL CODE SECTION 1798 et seq.) REQUIRES THIS NOTICE TO BE PROVIDED WHEN COLLECTING PERSONAL INFORMATION. ALL INFORMATION REQUESTED ON THIS FORM IS VOLUNTARY. THE CALIFORNIA DEPARTMENT OF FORESTRY AND FIRE PROTECTION WILL USE THE INFORMATION PROVIDED ON THIS FORM TO SECURE APPROPRIATE MEDICAL CARE IN THE EVENT OF AN EMERGENCY (LABOR CODE 3551). EMPLOYEES HAVE THE RIGHT OF ACCESS TO THE EMERGENCY NOTIFICATION FORM UPON REQUEST.

SECTION A: EMPLOYEE INFORMATION

NAME:	TITLE:	DATE:
HOME ADDRESS:	CITY/STATE/ZIP CODE:	HOME PHONE:
WORK LOCATION/UNIT:	ADDRESS/CITY/STATE/ZIP CODE:	WORK PHONE:

SECTION B: PERSON TO NOTIFY IN CASE OF INJURY OR ILLNESS

NAME:	**FIRST CHOICE:**	**SECOND CHOICE:**
WORK PHONE:	( ) -	( ) -
WORK ADDRESS/CITY:		
HOME PHONE:	( ) -	( ) -
HOME ADDRESS/CITY/ STATE/ZIP CODE:		

SECTION C: PHYSICIAN DESIGNATION

FOR A WORK RELATED INJURY/ILLNESS:
INDICATE IF YOU WISH TO BE TREATED BY YOUR REGULAR PERSONAL PHYSICIAN, WHO IS YOUR PRIMARY CARE PHYSICIAN, WHO HAS TREATED YOU BEFORE AND WHO HAS YOUR MEDICAL TREATMENT RECORDS. *THIS PHYSICAN MUST AGREE TO ACT AS THE WORK-RELATED INJURY/ILLNESS TREATING PHYSICIAN BY SIGNING THIS FORM*. SPECIFY THE NAME, PHONE NUMBER, AND ADDRESS OF THE PHYSICIAN. IF YOU DO NOT SELECT YOUR TREATING PHYSICIAN, A MEDICAL PROVIDER WILL BE SELECTED FROM THE PROVIDER LISTED ON THE "NOTICE TO EMPLOYEES" POSTED AT YOUR WORK LOCATION.

FOR A NON-WORK RELATED INJURY OR ILLNESS:
SPECIFY THE NAME OF YOUR PREFERRED MEDICAL DOCTOR AND/OR MEDICAL FACILITY YOU WISH TO BE REFERRED TO IF YOU ARE UNABLE TO PERSONALLY MAKE THIS NOTIFICATION.

WORK RELATED INJURY/ILLNESS	**NON-WORK RELATED INJURY/ILLNESS**
DOCTOR/FACILITY:	DOCTOR/FACILITY:
PHONE NUMBER: ( ) -	PHONE NUMBER: ( ) -
ADDRESS/CITY:	ADDRESS/CITY:

WORK-RELATED INJURY/ILLNESS TREATING PHYSICIAN SIGNATURE **DATE**

SECTION D: VOLUNTARY MEDICAL INFORMATION

DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

IN CASE OF A MEDICAL EMERGENCY, IS THERE ANY MEDICAL INFORMATION THAT MAY BE NECESSARY TO BE RELEASED FOR YOUR SAFETY?
☐ YES ☐ NO If yes, please include any special instructions here (e.g. allergies to medication), please specify. _____

I HEREBY AUTHORIZE ALL ABOVE INFORMATION TO BE RELEASED IN CASE OF A MEDICAL EMERGENCY:

EMPLOYEE SIGNATURE:	**DATE:**

PLEASE NOTE: Employees may voluntarily provide a copy to: Supervisor, Official Personnel File, Incident Command Center, Emergency Command Center/Physician.