

**EMERGENCY MANAGEMENT IDENTIFICATION CARD
STANDARD DATA ENTRY FORM**

By completing this form, I acknowledge that I am granting the Agency Having Jurisdiction (AHJ) permission to use the following information to create and manage an emergency management credential that, upon approval, will be issued to me. This form, along with a profile photograph and any copies of qualifications to be added shall be submitted to the AHJ as a complete package. By also signing this form, I acknowledge, that should the credential issued be requested to be returned or if I should leave the organization, I shall send it back to the originating AHJ.

Printed Name

Signature

Date

ANY FIELD PROCEEDED BY AN ASTERISK (*) IS A REQUIRED FIELD

PERSONNEL INFORMATION

The following information associates the individual with an organization and associated position responsibilities:

TITLE (Mr., Mrs., Dr., etc.)	
* LAST NAME (Up to 25 characters)	
* FIRST NAME (Up to 25 characters)	
* MIDDLE INITIAL	
SUFFIX (Sr., Jr., II, III, etc.)	
* PERSONAL ID (Last name + First letter of first name + Last five (5) digits of Social Security Number (e.g. DoeJ12345))	
* DATE OF BIRTH (mm/dd/yyyy)	
* ORGANIZATION (Enter the full name of the <u>primary</u> organization the applicant works for)	
RANK (Capt., Lt., FF, BC, Sgt., etc.)	
STATUS (Active, full time, part paid, volunteer)	
HIRE DATE (mm/dd/yyyy)	

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PERSONAL INFORMATION

ADDRESS TYPE (Home, Business)	
STREET ADDRESS	
CITY	
STATE	
ZIP CODE	
DRIVER LICENSE STATE	
DRIVER LICENSE NUMBER (Driver license # with class and endorsements (e.g. 1234567 B, P))	
DRIVER LICENSE EXPIRATION (mm/dd/yyyy)	
HOME PHONE NUMBER (Include area code)	
* WORK PHONE NUMBER (Include area code)	
FAX NUMBER (Include area code)	
MOBILE PHONE NUMBER (Include area code)	
E-MAIL ADDRESS	
* EMERGENCY POC NAME (Full name of person to be contacted in case of an emergency)	
* EMERGENCY POC NUMBER (Include area code)	
RELIGION	
OTHER ID NUMBER (Call sign, radio #, badge #, or other issued number by the AHJ. If unknown, leave blank.)	

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MEDICAL INFORMATION

First response and emergency management agencies (supporting and coordinating) are not deemed as a "covered entity" or "business associate" as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Therefore, voluntarily gathering certain medical information for employee safety and then sharing it with emergency medical services providers does not require an information release waiver (45 CFR Parts 160 and 164). A medical barcode may be added to the issued credential in order that, should you become injured or incapacitated, pertinent medical information can be provided to EMS providers.

GENDER (Male, Female)	
BLOOD TYPE (Enter blood type of applicant if known)	
ORGAN DONOR (YES / NO)	
* ALLERGIES (Enter any and all known allergies. If none, enter NKDA)	
HAIR COLOR (Blonde, Brown, Black, etc.)	
EYE COLOR (Blue, Brown, Hazel, etc.)	
MEDICAL HISTORY (Enter any pertinent medical history that is to be shared with EMS providers.)	
PHYSICIAN NAME	
PHYSICIAN PHONE NUMBER (Include area code)	
MEDICATIONS (List any and all medications you routinely take for sharing with EMS providers)	
HEIGHT (Feet and inches)	
WEIGHT (In pounds)	

