

Summit Fire Department Mass Casualty Incident

Patient Information / Emergency Contact Form

Last Name _____ First Name _____ M.I. _____

Address _____ Apt/Unit # _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

Age _____ Date of Birth _____

Organization / Group that is sponsoring you _____

In Case of Emergency...Please notify :

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____