



CONSUMER EMPLOYEE INFORMATION

Name: _____ Phone #: _____

Address: _____ City: _____ St/Zip _____

Date of Birth: _____ M or F _____ SSN # _____

Medical Ins. _____ SSI or SSDI _____

Medicaid # _____ Medicare# _____

Home/Residential Contact: _____ Phone # _____

Pager/Cell Phone _____

Emergency Contact : _____ Phone # _____ Relationship _____

Case Manager: _____ Phone # _____ Pager: _____

Employment Specialist: _____ Phone # _____ Pager _____

Employment Site: _____ Phone #: _____

Communication Ability: _____

Physical Challenges: _____

Allergies: _____

Does Employee have Seizures? Yes or NO. If yes, How often? _____

Medications used and how they are administered: _____

Other Specialized Medical Information: _____

Consumer Signature: _____ Date: _____

