VASCULAR ACCESS PLUS

EMERGENCY NOTIFICATION FORM

NAME: _____
ADDRESS: _____
CELL PHONE: _____
HOME PHONE: _____

PRIMARY EMERGENCY CONTACT INFORMATION
NAME: _____
ADDRESS: _____
PHONE: _____

SECONDARY EMERGENCY CONTACT INFORMATION
NAME: _____
ADDRESS: _____
PHONE: _____

PRIMARY CARE PHYSICIAN
NAME: _____
ADDRESS: _____
PHONE: _____

I understand that in the case of an emergency the management of Vascular Access Plus *will notify my emergency contact. I understand that I will notify management of* Vascular Access Plus *if there is a change in emergency contact information.*

SIGNATURE: _____