C&RCFD 043 REV 07/04

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH CARE REGULATION AND LICENSING ADMINISTRATION

DEPARTMENT OF HEALTH

CHILD DEVELOPMENT FACILITY EMPLOYEE HEALTH INFORMATION
(Print or type)

Facility: _____

Address: _____
Street City State/Zip Code

Telephone: ( ) _____

Employee Name: _____

Date of Birth: _____

Employee Address: _____
Street City State/Zip Code

Home Telephone: ( ) _____

Known Allergies: _____

Physician: _____ Telephone: ( ) _____

Address: _____
Street City State/Zip Code

Person to be contacted in an emergency:

Name: _____ Relationship: _____

Address: _____
Street City State/Zip Code

Telephone: ( ) _____

I have ☐ have no ☐ health insurance (check one).

Health Insurance Company: _____

Insurance Coverage: _____

Employee's Signature: _____ Date: _____

PLEASE RETAIN A COPY FOR YOUR RECORDS