

EMERGENCY RELOCATION ASSISTANCE FORM

Company: _____ Floor(s): _____

Primary Contact: _____ Phone: _____

Employee Information: Please list the name, location, and phone number of individuals who are mobility impaired that may require assistance during an emergency. This includes individuals with permanent disabilities or temporary disabilities such as persons with a broken leg or pregnant. Please also indicate the type of disability and two Relocation Aids. A relocation Aid is a co-worker that has been requested by the individual to assist them during an emergency.

Employee Name	Location on Floor	Phone Number	Type of Disability	Relocation Aid