Dresden University of Technology

ACCIDENT REPORT / EMPLOYEES
in case of accidents with a **visit to the doctor** and no or up to three days' inability to work

to: Unit Safety at Work
from:

....
Office stamp/telephone

Last name, first name Date of birth

Postal code Place, street

Employed as

Place of accident (building, room) Time of accident: Date Hours/minutes

Injured body parts Type of injury

Did the injured person stop working?

No Immediately Later, on: (Date):

Who was the first to become aware of the accident? Name/address

Description of the accident (in the case of traffic accidents, also state the police office that recorded the accident)
If necessary - use the lower part of the page for detailed description!

....	....	....
Date	Responsible leader / name, telephone	Safety officer / name, telephone

Detailed description of the accident

unofficial translation - do not fill in

As of: March 30, 2026