check for new version

TECHNISCHE UNIVERSITÄT DRESDEN

# 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