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