

# Accident Report

<b>Name and Surname</b>			
<b>Accident type</b>			
<b>Date and time of the accident</b>	<b>Date:</b>	<b>Hour:</b>	
<b>Location of the accident</b>			
<b>Description of the accident</b>			
<b>Last day and hour you worked before the accident</b>		<b>Date:</b>	<b>Hour:</b>
<b>Injured part of the body (left/right)</b>			
<b>Nature of the injury</b>			
<b>Name, Surname, address of doctor/hospital</b>			
<b>Following treatment by doctor/hospital</b>			
<b>Sick-leave since</b>	<b>No sick-leave</b>		
<b>Resumption of work</b>			
<b>Do you need the form for the pharmacy?</b>	<b>Yes</b>	<b>No</b>	

For analysis purposes, this form is also sent to the Occupational Health and Safety department (OHS) if it is related to an occupational accident