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| **1** Name und Anschrift des Unternehmens | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2** Unternehmensnummer des Unfallversicherungsträgers | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **3** Empfänger/-in | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **4** Name, Vorname der versicherten Person | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **5** Geburtsdatum | | | | | | Tag | | | | | | Monat | | | | | Jahr | | | | | | | |
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| **6** Straße, Hausnummer | | | | | | | | | | | | | | | Postleitzahl | | | | | | | | | | | | | | | Ort | | | | | | | | | | | | | | | | | | | | | | | | |
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| **7** Geschlecht | | | | | | | **8** Staatsangehörigkeit | | | | | | | | | | | | | | | | | | | | | | | **9** Leiharbeitnehmer/-in | | | | | | | | | | | | | | | | | | | | | | | | |
| Männlich  Weiblich | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | Ja  Nein | | | | | | | | | | | | | | | | | | | | | | | | |
| **10** Auszubildende/-r  Ja  Nein | | | | | | | **11** Die versicherte Person ist | | | | | | | | | | | |  | | | | Unternehmer/-in | | | | | | | | | | | |  | | mit der Unternehmerin/ dem Unternehmer: | | | | | | | | | | | | | | | | | |
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| **12** Anspruch auf Entgeltfortzahlung | | | | | | | | | | | **13** Krankenkasse (Name, PLZ, Ort) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| besteht für | | |  |  | Wochen | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **14** Tödlicher Unfall? | | | | | | **15** Unfallzeitpunkt | | | | | | | | | | | | | | | | | | | | | | | | | | **16** Unfallort (genaue Orts- und Straßenangabe mit PLZ) | | | | | | | | | | | | | | | | | | | | | | |
| Ja  Nein | | | | | | Tag | | | Monat | | | Jahr | | | | | | | | Stunde | | | | | | Minute | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
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| **17** Ausführliche Schilderung des Unfallhergangs (Verlauf, Bezeichnung des Betriebsteils, ggf. Beteiligung von Maschinen, Anlagen, Gefahrstoffen) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Die Angaben beruhen auf der Schilderung  der versicherten Person  anderer Personen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **18** Verletzte Körperteile | | | | | | | | | | | | | | | | | | | | | | | | **19** Art der Verletzung | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **20** Wer hat von dem Unfall zuerst Kenntnis genommen? (Name, Anschrift) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | War diese Person Augenzeugin/Augenzeuge des Unfalls? | | | | | | | | | | | | | | | | | | | | | |
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| **21** Erstbehandlung:  Name und Anschrift der Ärztin/des Arztes oder des Krankenhauses | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **22** Beginn und Ende der Arbeitszeit  der versicherten Person | | | | | | | | | | | | | | | | | | | | | | | |
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| **23** Zum Unfallzeitpunkt beschäftigt/tätig als | | | | | | | | | | | | | | | | | | | | | | | | | | | **24** Seit wann bei dieser Tätigkeit? | | | | | | | | | | | | | | | | | Monat | | | | Jahr | | | | | | |
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| **25** In welchem Teil des Unternehmens ist die versicherte Person ständig tätig? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **26** Hat die versicherte Person die Arbeit eingestellt?  Nein  Sofort Später, am | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Tag | | | | | Monat | | | | Stunde | | | |
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| **27** Hat die versicherte Person die Arbeit wieder aufgenommen?  Nein  Ja, am | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Tag | | | | | | Monat | | | | | Jahr | | | | | | | |
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| **28** Datum | | | | Unternehmer/-in (Bevollmächtigte/-r) | | | | | | | | | | | | | Betriebsrat (Personalrat) | | | | | | | | | | | | | | | | | | | | | | Telefon-Nr. für Rückfragen | | | | | | | | | | | | | | | |