

Accident Report Form

Person involved in the accident

Surname
First name(s)
Date of birth
Street, house number
Postcode, city
Telephone
Email
Nationality
Marital status
AHV (Social security) no. 756.
Gender male female
Children yes no number
Liable to tax at source? yes no
Language German French
Italian English

Employment

Start date
Profession
Rank in profession
(employee / management)
Normal place of work

Contractual relationship

Permanent contract ja nein
Temporary contract until
Contract terminated as from
Working hours (hours per week)
Usual weekly working hours in the company
Workload (in %)
Working days (regular, irregular)

Date of accident

Day / month / year
Time

Place of accident

Place (name of town /
city or postcode)
Location (e. g. workshop /
street)

Facts

Description of the
accident (objects /
vehicles involved)

Persons involved

Police report? yes no

Accident outside of work

Until when did you work
before the accident? Date Time

Incapacity for work lasting more than three days

Work stopped on Date Time

Provisional duration
of incapacity:
in excess of 1 month yes no

Went back to work on Date

Work rate on return Percent

Injury

Affected part of the body

Side

Nature of injury

Doctor's address

Title/department/hospital

Surname, first name(s)

Street, house number

Postcode, city

Subsequent treatment
from (name of Dr)

Miscellaneous

Do you already have any
other daily benefit or
pension entitlements?

Remarks