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|  | | | | | | | | | | | | | | | | | **UNFALLANZEIGE** | | | | | | | | | | | | | | | | | |
| **1** Name und Anschrift der Einrichtung (Tageseinrichtung, Schule, Hochschule) | | | | | | | | | | | | | | | | | für Kinder in Tageseinrichtungen,  Schüler, Studierende | | | | | | | | | | | | | | | | | |
| **2** Träger der Einrichtung | | | | | | | | | | | | | | | | | |
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| **4** Empfänger/in | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
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| **5** Name, Vorname der versicherten Person | | | | | | | | | | | | | | | | | | | **6** Geburtsdatum | | | | | Tag | | | | Monat | | | Jahr | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | |
| **7** Straße, Hausnummer | | | | | | | | | Postleitzahl | | | | | | | | | | Ort | | | | | | | | | | | | | | | |
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| **8** Geschlecht | | | | | **9** Staatsangehörigkeit | | | | **10** Name und Anschrift der gesetzlich Vertretungsberechtigten | | | | | | | | | | | | | | | | | | | | | | | | | |
| männlich  weiblich | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **11** Tödlicher Unfall? | | | | **12** Unfallzeitpunkt | | | | | | | | | | | | | | **13** Unfallort (genaue Orts- und Straßenangabe mit PLZ) | | | | | | | | | | | | | | | | |
| ja  nein | | | | Tag | | Monat | Jahr | | | Stunde | | | | | Minute | | |  | | | | | | | | | | | | | | | | |
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| **14** Ausführliche Schilderung des Unfallhergangs (insbesondere Art der Veranstaltung, bei Sportunfällen auch Sportart) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Die Angaben beruhen auf der Schilderung  der versicherten Person  anderer Personen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **15** Verletzte Körperteile | | | | | | | | | | | | | | **16** Art der Verletzung | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **17** Hat die versicherte Person den Besuch der Einrichtung unterbrochen? | | | | | | | | nein  sofort später am | | | | | | | | | | | | | | | | | | | | Tag | | | Monat | | Stunde | |
|  | |  |  |  |  |  |
| **18** Hat die versicherte Person den Besuch der Einrichtung wieder aufgenommen? | | | | | | | | nein  ja, am | | | | | | | | | | | | | | | | Tag | | | | Monat | | | Jahr | | | |
|  | |  | |  | |  |  |  |  |  |
| **19** Wer hat von dem Unfall zuerst Kenntnis genommen? (Name, Anschrift) | | | | | | | | | | | | | | | | | | | | | | | | War diese Person Augenzeuge? | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | ja  nein | | | | | | | | | | |
| **20** Erstbehandlung: Name und Anschrift der Ärztin / des Arztes oder des Krankenhauses | | | | | | | | | | | | | | | | | | | | **21** Beginn und Ende des Besuchs der Einrichtung | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | Stunde | | | Minute | | | |  | | Stunde | | Minute | |
| Beginn | |  |  | |  | |  | | Ende | |  |  |  |  |
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| **22** Datum | | | Leiter/in (Beauftragte/r) der Einrichtung | | | | | | | | | | | | | | | | | | Telefon-Nr. für Rückfragen | | | | | | | | | | | | | |