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| --- | --- |
| **Injured person** | |
| **Full name** | Click to enter text. |
| **Danish civil registration number (CPR)** | Click to enter text. |
| **E-mail (private)** | Click to enter text. |
| **Phone number (private)** | Click to enter text. |
| **Start date of employment**  *For students: the date of the commencement of your studies* | Click to enter text. |
| **Job title** | Click to enter text. |
| **Department/unit and its address** | Click to enter text. |
| **Annual income**  *Open ‘select an item’ and select an item from the list by clicking the arrow on the right.* | Select an item. |

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| **Accident** | |
| **Time and place** | |
| **Where did the accident happen?**  *If possible, please specify the address* | Click to enter text. |
| **Date of the accident** | Click to select a date. |
| **Time of the accident** | Click to enter text. |
| **Detailed description of the accident** | |
| **What was the injured person doing just before the accident happened?** | Click to enter text. |
| **What went wrong?** | Click to enter text. |
| **How was the injury sustained?** | Click to enter text. |

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| **Personal injury** | |
| **Please describe the injury as accurately as possible** | |
| **Which part of the body was injured?**  *Please provide details in the text box, such as right/left hand side, several injuries etc.* | Select an item.  Click to enter text. |
| **What type of injury was sustained?** *Please provide details in the text box, such as several injuries, extensive injuries etc.* | Select an item.  Click to enter text. |
| **Additional information** | |
| **Absence after the day of the accident**  *Please note: the day of the accident is not included in the total period of absence.* | Select an item. |
| **Medical treatment** | |
| **Has the injured person been treated by a doctor or hospital in connection with this injury?** | Doctor  Hospital  When? Click to select a date. |
| **Documentation attached**  *In the text box, please provide a description of any documentation, which you wish to attach to this report, such as reports from emergency room, photos etc. You must attach this documentation to the email in which you send this report.*  *Don’t attach expenses, this will be handled later in the process.* | Click to enter text. |
|  | |
| **Prevention of similar accident** | |
| **What type of preventive actions must be taken to avoid similar accidents?** | Click to enter text. |
| **Who is responsible for these actions?** | Click to enter text. |
| **Deadline for completion of the preventive actions? When do we follow up on whether they work?** | Click to enter text. |
|  | |
| Assessment according to the Consolidated Workers’ Compensation Act | |
| **Do you wish for the accident to be assessed according to the Consolidated Workers’ Compensation Act (Arbejdsskadesikringsloven) in terms of compensation?** | Yes  No  Don’t know |

Date: Date: Date:

The injured person Occupational health and safety representative Manager

**Please send the report and any appendices to** [**ulykke@adm.aau.dk**](mailto:ulykke@adm.aau.dk)