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| **ANZEIGE BEI VERDACHT AUF EINE BERUFSKRANKHEIT DURCH ERKRANKTE PERSON** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | Berufsgenossenschaft der Bauwirtschaft - BG BAU  Berufskrankheiten-Anzeige  30682 Hannover | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name, Vorname | | | | | | | | | | | | | | | Geschlecht | | | | | | | | | | | | | | | Geburtsdatum | | | | | Tag | | | Monat | | | Jahr | | | | | |
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| Straße, Hausnummer | | | | | | | | | | | | | | | | | | | Postleitzahl | | | | | | | | | | | | Ort | | | | | | | | | | | | | | | |
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| Welche Krankheitserscheinungen oder Beschwerden liegen vor? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wann traten die Beschwerden erstmals auf? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Befanden Sie sich wegen der genannten Beschwerden bereits in ärztlicher Behandlung? Wenn ja, geben Sie bitte den Arzt/die Ärztin bzw. das Krankenhaus mit Anschrift an. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nein  Ja  Name und Anschrift: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Worauf führen Sie Ihre Beschwerden zurück? (wenn möglich, bitte konkrete Arbeitsstoffe oder Tätigkeiten angeben) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Sind oder waren Sie aufgrund der genannten Beschwerden arbeitsunfähig?  Nein  Ja | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Von | | | | Tag | | | | Monat | | | | | Jahr | | | | | | | | | | | | Bis | | | Tag | | | | | Monat | | | | Jahr | | | | | | | | | |
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| Laufend | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In welchem Unternehmen sind oder waren Sie zuletzt tätig? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Tätigkeit als: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name Ihrer Krankenkasse (Name und Anschrift): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Weitere Kontaktdaten Telefonnummer:       Handynummer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Datum | | | | | | | | | | | | | | | | | | | | Unterschrift | | | | | | | | | | | | | | | | | | | | | | | | | | |