**COMUNICAÇÃO INTERNA DE ACIDENTES**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DADOS DO(A) ACIDENTADO(A):** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Servidor(a) | Estagiário(a) | | | | | | | | | | | Outro: \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| Nome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CPF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | RG:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emissão: \_\_\_/\_\_\_/\_\_\_\_ Expedidor:\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| Endereço: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Nº: \_\_\_\_\_\_\_ | | | | | Compl.: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Bairro: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Cidade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | UF:\_\_\_\_\_ | | | | CEP:\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_ | | | |
| Telefone residencial: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ | | | | | | | | | | | | | Telefone celular: (\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| Data nascimento: \_\_\_/\_\_\_/\_\_\_\_ | | | | | | | | | Idade: \_\_\_\_\_ | | | | | | Sexo: fem masc | | | | | | | | | | Estado civil:\_\_\_\_\_\_\_\_\_ | | | |
| Setor de trabalho: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | Ramal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Cargo efetivo:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | Função de confiança: sim não | | | | | | | | |
| Siape: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Admissão: \_\_\_/\_\_\_/\_\_\_\_ | | | | | | | | | | | |  | | | | | | | | | | | |
| Horário de trabalho: | | | das \_\_\_\_:\_\_\_\_ às \_\_\_\_:\_\_\_\_ e das \_\_\_\_:\_\_\_\_ às \_\_\_\_:\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |
| **DADOS DO ACIDENTE:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Data: \_\_\_/\_\_\_/\_\_\_\_ | | Hora: \_\_\_\_:\_\_\_\_ | | | | | | | | | Após \_\_\_\_ horas de trabalho. | | | | | | | | | | | Estava realizando hora extra?  sim não | | | | | |
| Local do acidente: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Agente causador: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Partes do corpo atingidas: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Registro Policial:  não  sim: | | | | | | | | Nº da ocorrência: \_\_\_\_\_\_\_\_\_\_\_\_\_ Data: \_\_\_/\_\_\_/\_\_\_\_ Distrito: \_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| Descrever o que fazia o acidentado e como ocorreu o acidente: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DADOS DA(S) TESTEMUNHA(S) VISUAIS (V) E/OU CIRCUNSTANCIAIS (C):** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  V C | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Endereço: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Nº: \_\_\_\_\_\_\_ | | | | | Compl.: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Bairro: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Cidade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | UF:\_\_\_\_\_ | | | | CEP:\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_ | | | |
| Telefone residencial: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ | | | | | | | | | | | | | Telefone celular: (\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  V C | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Endereço: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | Nº: \_\_\_\_\_\_\_ | | | | | Compl.: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Bairro: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Cidade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | UF:\_\_\_\_\_ | | | | CEP:\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_ | | | |
| Telefone residencial: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ | | | | | | | | | | | | | Telefone celular: (\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,  Local | | | | | | | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  Data | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assinatura/Carimbo do Chefe do setor envolvido em Acidente | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PARA USO DA SEBEN:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |
| Recebido por: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Data: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Hora: \_\_\_\_:\_\_\_\_ | | | | | | | | | | | | | | | Encaminhado para SIASS em: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  Resp.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |

**LAUDO / SERVIÇO MÉDICO A QUE FOI ENCAMINHADO**

**(PREENCHIDO PELO MÉDICO)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Local: | | Data atendimento: \_\_\_/\_\_\_/\_\_\_\_ | | | Hora: \_\_\_\_:\_\_\_\_ | |
| Internação: ( ) Sim( ) Não | Afastamento: ( ) Sim( ) Não | | Duração tratamento: | | | CID: OBRIGATÓRIO |
| Natureza lesão: | | | | | | |
| Observações: | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Ass. médico: | | | | CRM: | | |