HEALTHCARE REQUEST

1. COMPANY DETAILS

COMPANY	DELEGATION	CONTRIBUTION ACCOUNT CODE
		/ /

TYPE OF ACCIDENT

☐ ACCIDENT ☐ IN ITINERE ACCIDENT (on the way to/from work) ☐ ACCIDENT DURING A WORK TRAVEL

2. INJURED WORKER DETAILS

NAME AND SURNAMES		ID NUMBER	
SOCIAL SECURITY AFFILIATION NO. / /	TYPE OF CONTRACT	WORKING HOURS Start time 00:00	End time 00:00
JOB POSITION	OCCUPATION	TRAINING RECEIVED	
TASKS			

3. EVENT DETAILS

ACCIDENT DATE				ACCIDENT TIME	
Day	Month	Year	Weekday Select	Time	Minutes

NAME AND SURNAMES OF THE WITNESS:

Location of the accident (Address):	Was he/she in her workplace? ☐ YES ☐ NO

DESCRIPTION OF THE WORK YOU WERE DOING:

DETAILED DESCRIPTION OF THE WAY THE ACCIDENT HAPPENED:

WHY DID THE ACCIDENT HAPPEN? REASONS THAT CAUSED THE INCIDENT:

WHAT HAPPENED TO THE WORKER? WAS HE/SHE HURT? DESCRIPTION OF VISIBLE DAMAGES (CUTS, BRUISES, ETC.)

WHAT PART OF THE BODY DID HE/SHE INJURE?

MUTUA BALEAR, MUTUA COLABORADORA CON LA SEGURIDAD SOCIAL Nº 183, SEGÚN REGISTRO OFICIAL DEL MINISTERIO, C.I.F. G 07046196

MUTUA BALEAR

HEALTHCARE **REQUEST**

PDF file with interactive form. *You can use your computer to fill the fields,save and/or print this document.*

ASSISTANCE REQUESTED BY THE WORKER?	☐ YES	☐ NO

NOTES

1. The issuance of this request for health care does not imply recognition by the Mutual of the concurrence of an accident at work.
2. The presentation of this document in Medical Services other than those of MUTUA BALEAR does not imply that this Mutua must necessarily assume the cost of the care provided.
3. In the event that the Mutual qualifies the incident as a work accident, in accordance with current legal provisions, the company must:
   a) If it causes medical leave: process the corresponding work accident report, through the Delt@ system (within five days following the date of issuance of the medical leave or within 24 hours in the event of a serious, very serious or death.)
   b) If it does not cause medical leave: include this process in the list of work accidents without medical leave (Delt@) for the month following the assistance.

Whenever you need more assistance request flyers, you can request them at our offices or download them from our website: www.mutuabalear.es

MUTUA BALEAR, MUTUA COLABORADORA CON LA SEGURIDAD SOCIAL Nº 183, SEGÚN REGISTRO OFICIAL DEL MINISTERIO, C.I.F. G 07046196

Signature and company stamp

Filled by: _____
(Name and Surname)

Position:_____ Phone: _____

In _____ on the _____ of _____ 20____

DELETE ALL
Can't be undone

SEND PRINT SAVE

Basic information on privacy: All data is mandatory for the correct processing of your request. The data controller is MUTUA BALEAR, MCSS nº183. The purpose is the processing and management of the assistance and economic benefits to which the self-employed or mutual workers are entitled, the fulfillment of legal obligations and quality management purposes. Interested parties have the right to request access, rectification or deletion, limitation of the treatment and portability of their data, as well as to oppose their treatment and to file a claim with a control authority. More information about data protection and your rights in the privacy policy for mutual companies at https://www.mutuabalear.es/es/portal-privacidad

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