Please send your report to:
SRF AB
Att: Skador
Box 16250
103 24 Stockholm
or
skador@srfab.net

Reference number:
(To be filled in by SRF)

PATIENT INJURY REPORT FORM

DETAILS OF THE CLAIMANT

Surname	Given Name
Social Security Number	
Residential Address	Postal code and City
Telephone	E-mail
Preffered way of communication ☐ E-mail ☐ Telephone ☐ Post	

OTHER NOTIFIER – PERSONAL DATA OF THE NOTIFIER/CONTACT PERSON

Surname	Given Name
Telephone	E-mail

DETAILS ABOUT THE ACCIDENT

Date of the accident
Describe the injury, when and how it occurred

Name of the clinic where the accident occurred	
Address of the clinic	
Other details	
Contact person at the clinic	Telephone number

SIGNATURE

I hereby certify that the information provided in this for is accurate and complete to the best of my knowledge

City and date

Signature of the	Signature of other notifier
Printed name	Printed name

All personal data is managed in strict accordance with the General Data Protection Regulation (GDPR).
For detailed information about GDPR, your rights, and our data-handling practices, please visit our official website at www.srfab.net.