|  |  |  |
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|  |  | **Austauschnummer - E** **/**  |

|  | Alphabetisch:- **Vorname**- **Name** | **M** | **W** | **Geburtsdatum**(TT.MM.JJJJ) | **Ausbildungsberuf** **(Bitte genaue Berufs-bezeichnung angeben)** | **Anschrift des Teilnehmenden** | **Name und Anschrift des/r gesetzlichen Vertreters/in** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1** |            | [ ]  | [ ]  |       |       |       |       |
| **2** |            | [ ]  | [ ]  |       |       |       |       |
| **3** |            | [ ]  | [ ]  |       |       |       |       |
| **4** |            | [ ]  | [ ]  |       |       |       |       |
| **5** |            | [ ]  | [ ]  |       |       |       |       |
| **6** |            | [ ]  | [ ]  |       |       |       |       |
| **7** |            | [ ]  | [ ]  |       |       |       |       |
| **8** |            | [ ]  | [ ]  |       |       |       |       |
| **9** |            | [ ]  | [ ]  |       |       |       |       |
| **10** |            | [ ]  | [ ]  |       |       |       |       |
| **11** |            | [ ]  | [ ]  |       |       |       |       |
| **12** |            | [ ]  | [ ]  |       |       |       |       |
| **13** |            | [ ]  | [ ]  |       |       |       |       |
| **14** |            | [ ]  | [ ]  |       |       |       |       |
| **15** |            | [ ]  | [ ]  |       |       |       |       |
| **16** |            | [ ]  | [ ]  |       |       |       |       |

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| Ich bestätige, dass alle Teilnehmenden krankenversichert sind. |
|  |
|       |       |  |
| Ort | Datum | Unterschrift des/r Leiters/in der Einrichtung |