FIRST AID REPORT

This record must be kept by the employer for three (3) years. This form must be kept at the employer's workplace. Do NOT submit to Workers Compensation Boards.	Sequence Number

Name	**Occupation/Job Title**
Worker Phone Number	**Date of Birth (optional)**
Date of Injury (yyyy-mm-dd)	**Location of Incident**
Time of Injury or Illness (hh:mm)	**Initial Reporting Date & Time (yyyy-mm-dd hh:mm)**
☐ **am** ☐ **pm**	☐ **am** ☐ **pm**

What happened?
Describe what the worker was doing before the incident, what happened, and how they were injured.
Provide as many details as possible.

What symptoms and/or signs do you see?
Describe the injury, exposure, or illness. Include applicable size, which side of body, and general assessment notes.

What did you do?
Describe what assessments you completed, the results, and the subsequent treatment given.

Name of witnesses

1.	2.

Arrangement made for the worker (Circle one).

RETURN TO WORK	FOLLOW-UP	TRANSPORT TO MEDICAL	AMBULANCE

Details of Transportation Arrangement (if necessary):

Date & Time of Follow-up (if necessary)		**Alternate duty options were discussed**	Y	N

First Aid Attendant Name	**First Aid Attendant Signature**

Patient Signature