**FIRST AID REPORT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of injury or illness: |  | Time |  | AM  PM |
| DAY MONTH YEAR |  |  |  |
| Date injury or illness REPORTED: |  | Time |  | AM  PM |
| DAY MONTH YEAR |  |  |  |

|  |  |
| --- | --- |
| Full name of injured or ill worker: |  |

Description of the injury or illness:

|  |
| --- |
|  |

Description of where the injury or illness occurred / began:

|  |
| --- |
|  |

Cause of the injury or illness:

|  |
| --- |
|  |

First Aid provided? YES  NO

|  |  |
| --- | --- |
| Name of First Aider: |  |

First Aider Qualifications:

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency First Aider |  | Emergency Medical Technician – Paramedic |  |
| Standard First Aider |  | Emergency Medical Technician |  |
| Advanced First Aider |  | Emergency Medical Responder |  |

Describe first aid provided:

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Copy provided to worker |  | Copy refused |  | Injured worker initials |  |

**Keep this record confidential and retain for at least 3 years from date of injury / illness is reported.**