**FIRST AID REPORT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of injury or illness: |       | Time |       | AMPM |
| DAY MONTH YEAR |  |  |  |
| Date injury or illness REPORTED: |       | Time |       | AMPM |
| 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.**