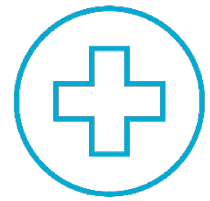


# First aid record form



Sample/template

Date of injury or illness: \_\_\_\_\_  
Day      Month      Year

Time: \_\_\_\_\_ AM  
PM

Date injury or illness reported: \_\_\_\_\_  
Day      Month      Year

Time: \_\_\_\_\_ AM  
PM

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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Emergency first aider | <input type="checkbox"/> Primary care paramedic  | <input type="checkbox"/> Emergency medical responder |
| <input type="checkbox"/> Standard first aider  | <input type="checkbox"/> Advanced care paramedic |  |
| <input type="checkbox"/> Advanced first aider  | <input type="checkbox"/> Nurse                   |  |

Describe first aid provided:  
\_\_\_\_\_  
\_\_\_\_\_

Copy provided to worker     Copy refused    Injured/ill worker initial \_\_\_\_\_

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