FIRST AID RECORD

	DAY	MONTH	YEAR	TIME		
DATE OF INJURY OR ILLNESS					**AM**	
					PM	
DATE OF INJURY OR ILLNESS REPORTED					**AM**	
					PM	

NAME OF INJURED / ILL EMPLOYEE _____

OCCUPATION: _____

ACCIDENT REPORT # _____

REPORTED TO: _____ **POSITION:** _____

DESCRIPTION OF THE ILLNESS OR INJURY _____

_____

_____

LOCATION WHERE THE INJURY OR ILLNESS OCCURRED

_____

_____

_____

CAUSE OF ILLNESS AND INJURY

_____

_____

_____

_____

_____

_____

FIRST AID PROVIDED Y OR N
IF YES PLEASE HAVE THE FIRST AIDER
COMPLETE THE SECTION BELOW

NAME OF FIRST AIDER: _____

SIGNATURE: _____

FIRST AIDERS QUALIFICATION

EMERGENCY FIRST AID	
STANDARD FIRST AID	
ADVANCED FIRST AID	
QUALIFIED NURSE	

TYPE OF FIRST AID PROVIDED

_____

_____

_____

_____

SUPPLIES USED: PROVIDE INVENTORY

_____

_____

_____

_____

_____

RETURN TO WORK	**Y**	
	N	
MEDICAL AID REQUIRED	**Y**	
	N	
LOST TIME	**Y**	
	N	

COPIES TO THE EMPLOYEE	
COPIES TO THE FOREMAN	

EMPLOYEE SIGNATURE _____ **DATE:** _____

MANAGERS SIGNATURE: _____ **DATE:** _____

TRANSFERRED TO STATISTICAL DOCUMENTS YES

BY WHO:_____ **DATE:** _____