

**THIS FORM IS TO BE COMPLETED BY THE FIRST AID ATTENDANT AND FAXED TO THE  
MANAGER, HUMAN RESOURCES/HEALTH AND SAFETY, SD 63 (SAANICH), AT 250-652-7372**

General Information	
Name	Occupation
School/Location	
Date (yyyy-mm-dd)	Time (hh:mm) <span style="float: right;">a.m. <input type="checkbox"/> p.m. <input type="checkbox"/></span>
Initial reporting date and time (yyyy-mm-dd)	Follow-up report date and time (yyyy-mm-dd)
Initial report sequence number	Subsequent report sequence number(s)
Description of how the injury, exposure, or illness occurred <i>(What happened?)</i>	
Description of the nature of the injury, exposure, or illness <i>(What you see – signs and symptoms)</i>	
Description of the Treatment Given <i>(What did you do?)</i>	
Name of Witnesses	
1)	2)
Arrangements Made Relating to Worker <i>(return to work/medical aid/ambulance/follow-up)</i>	
Provided worker handout      Yes <input type="checkbox"/> No <input type="checkbox"/> Alternate duty options were discussed      Yes <input type="checkbox"/> No <input type="checkbox"/>	A form to assist in return to work and follow-up was sent with the worker to medical aid      Yes <input type="checkbox"/> No <input type="checkbox"/>
First Aid Attendant's Name (please print)	First Aid Attendant's signature
Patient's signature	