The Occupational First Aid Attendant must complete this form when first aid is administered to employees.

### General Information

<table>
<thead>
<tr>
<th>Name of Injured Person (Last, First)</th>
<th>Job Title/Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location/site where incident occurred: (include school name)</td>
<td>Date of incident (yyyy-mm-dd)</td>
</tr>
<tr>
<td>Time of incident :</td>
<td>a.m.□ p.m.□</td>
</tr>
<tr>
<td>Initial report sequence number</td>
<td>Initial reporting date and time (yyyy-mm-dd)</td>
</tr>
<tr>
<td>Subsequent report sequence number</td>
<td>Follow-up report date and time (yyyy-mm-dd)</td>
</tr>
</tbody>
</table>

### Describe how the injury, exposure, or illness occurred (What happened?)

- [ ] Slip/trip  
- [ ] Fall  
- [ ] Contact with object  
- [ ] Caught between objects  
- [ ] Repetitive motion  
- [ ] Overexertion  
- [ ] Harmful substance  
- [ ] Other

### Describe the nature of injury, exposure or illness (What you see? – signs and symptoms)

- **Area**  
  - [ ] Head  
  - [ ] Face  
  - [ ] Chest  
  - [ ] Back  
  - [ ] Shoulder  
  - [ ] Arm  
  - [ ] Wrist  
  - [ ] Hand  
  - [ ] Leg  
  - [ ] Knee  
  - [ ] Ankle  
  - [ ] Foot  
  - [ ] Other

- **Type**  
  - [ ] No injury  
  - [ ] Pain/swelling  
  - [ ] Bruise/abrasion  
  - [ ] Strain/sprain  
  - [ ] Cut  
  - [ ] Fracture  
  - [ ] Loss of consciousness  
  - [ ] Other

### Describe the treatment given (What did you do?)

- [ ] Cleaned  
- [ ] Bandage/splint  
- [ ] Ice/cold compress  
- [ ] Assessed ABCs  
- [ ] CPR  
- [ ] Other

### Name of Adult Witnesses/ Persons with Relevant Information

1)  
2)

### Arrangements made relating to worker (return to work/ medical aid/ ambulance /follow-up)

- [ ] Yes □ No   
  - Provided worker handout  
- [ ] Yes □ No  
  - Alternate duty options were discussed  
- [ ] Yes □ No  
  - Return to work form sent with worker to medical aid  

**Comments:**

**Occupational First Aid Attendant Name (please print)**

**Occupational First Aid Attendant Signature**

**Patient’s Signature**

This record must be kept by the employer for three (3) years and is not to be submitted to WorkSafeBC.