FIRST AID/MEDICAL AID RECORD

Date of Injury: _____ Time of Injury: _____

Date Injury Reported: _____ Location: _____

Name of Injured Worker: _____

Description of Incident Leading to Injury: _____

_____

_____

_____

_____

Describe the Injury: _____

_____

_____

_____

Was First Aid provided? ☐ Yes ☐ No
(Band-Aid, Ice Pack, Compresses)

Was Medical Aid provided? ☐ Yes ☐ No
(Medical Professional, Doctor or Nurse)

Describe First Aid/Medical Aid provided: _____

_____

_____

_____

Qualifications & Name of Person providing First Aid/Medical Aid: _____

_____

◯ **The injured worker refused First Aid/Medical Aid.**

Signature of Injured Worker: _____

Supervisor's Name: _____ Signature: _____

Health & Safety Officer's Initials _____