

FIRST AID TREATMENT RECORD

Report # _____

Refer to Initial Report # _____

Date of Injury or Illness: _____ Time of Injury or Illness: _____ am/pm

Name (first, last): _____ Time and Date Reported: _____ am/pm

Occupation: _____

Supervisor: _____

Description of Injury, illness or disease: (include body part, type of injury, etc.)

FA

Description of how injury, illness or disease occurred: (include information such as work location, tools/equipment involved, nature of work activity, job performed)

MED

Description of First Aid Treatments Rendered or Arrangements Made:

Rec

Follow-up Treatments Required: Yes No **Date:** _____

Description of Follow-up Treatment Rendered:

OFAA (print name & sign) _____

Worker's Signature: _____

Witness (print name and sign) _____

Reported to supervisor: Yes No **Date:** _____

Supervisor Comments:

Case Remarks, Dispositions or Comments:

