

Form G – Record of First Aid Treatment

Date of injury or illness: _____ Time: _____ AM / PM

Full name of injured or ill individual: _____

Description of the injury or illness: _____

Description of where the injury or illness occurred/began: _____

Cause of the injury or illness: _____

First aid provided? Yes / No

Name of first aider: _____

First aider qualifications (Circle applicable):

Emergency First Aider

Emergency Medical Technician – Paramedic

Standard First Aider

Emergency Medical Technician

Advanced First Aider

Emergency Medical Responder

Nurse

None

Describe first aid provided: _____

Copy provided to injured Copy refused Injured worker initials: _____

Keep this record confidential and retain for at least 3 years from date of injury/illness is reported