University of Lethbridge
Health Safety
First Aid Record

Date injury/illness **OCCURRED**: *dd/mmm/yyyy*

Time (HH:MM) : ☐ am ☐ pm

Date injury/illness **REPORTED**: *dd/mmm/yyyy*

Time (HH:MM) : ☐ am ☐ pm

I.d.#:

Full name of injured or ill worker:

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 : *(if first aid provided)* Check if not applicable: ☐

First Aider qualifications: (*click on applicable qualifications)*

- ☐ Emergency First Aider
- ☐ Standard First Aider
- ☐ Advanced First Aider
- ☐ Nurse
- ☐ Emergency Medical Technician-Paramedic
- ☐ Emergency Medical Technician
- ☐ Emergency Medical Responder

Describe first aid provided: Check if not applicable: ☐

COPY OF THIS REPORT ONLY TO BE SUPPLIED TO WORKER IF REQUESTED

Indicate by clicking on applicable box

☐ Copy provided to worker ☐ Copy refused/Not requested

This form will not automatically save - Save form to file or print CLICK TO PRINT

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