First-Aid Treatment Record

Injured Person

Employee Name*: _____

Job Title: _____

Department: _____

Incident Details

Date of Incident*: _____

Time of Incident*: _____

Location of Incident*: _____

Body Part Affected*: _____ *> Options: Head, Eye, Ear, Nose, Mouth, Neck, Shoulder, Arm, Elbow, Wrist, Hand, Finger, Chest, Abdomen, Back, Hip, Leg, Knee, Ankle, Foot, Toe, Multiple, Other*

Nature of Injury/Illness*: _____ *> Options: Cut/Laceration, Bruise/Contusion, Burn, Fracture, Sprain/Strain, Puncture, Foreign Body, Illness, Other*

Description of Incident*: _____

_____

Treatment

Date of Treatment*: _____

First Aid Treatment Provided*: _____

_____

First Aider Name*: _____

First Aider Signature*: _____ *(Sign above)*

☐ **Referred to External Medical Facility**

Medical Facility Details: *(Fill only if applicable)*

_____

Witnesses

Witness List:

Name	Phone	Statement Summary