STRIKE	FIRST AID REPORT	CF-S-12

Date of Injury: _____ Time of Injury: _____: _____ ☐ a.m. *or* ☐ p.m.

Date Reported: _____ Time Reported: _____: _____ ☐ a.m. *or* ☐ p.m.

Name of Injured Worker: _____

Description of Injury: _____

_____

_____

Description of Where the Injury Occurred: _____

_____

_____

Cause of Injury: _____

_____

_____

Name of First Aid Attendant no. 1: _____

First Aid Attendant no. 1 - Qualifications: ☐ EFA ☐ SFA ☐ EMT/R ☐ MP

If applicable:
Name of First Aid Attendant no. 2: _____

First Aid Attendant no. 2 - Qualifications: ☐ EFA ☐ SFA ☐ EMT/R ☐ MP

Description of First Aid Provided: _____

_____

_____

_____

***EFA** = Emergency Frist Aid* ***SFA** = Standard First Aid* ***EMT/R** = Emergency Medical Technician/Responder*
***MP** = Medical Professional*

_____ _____ _____
Worker Signature ***Supervisor Signature*** ***Date Signed***

☐ Copy Provided to Injured Worker ☐ Copy Refused by Injured Worker Injured Worker Initials: _____

*****This report must be kept in a confidential file for a minimum of 3 years from the date of the injury.*****