



This record must be kept by the employer for three (3) years. This form must be kept at the employer's workplace. Do **NOT** submit to WorkSafeBC.

Sequence number

Name	Occupation
Date of injury or illness (yyyy-mm-dd)	Time of injury or illness (hh:mm) a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
Initial reporting date and time (yyyy-mm-dd) (hh:mm) a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Follow-up report date and time (yyyy-mm-dd) (hh:mm) a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
Initial report sequence number	Subsequent report sequence number(s)

Description of how the injury, exposure, or illness occurred (What happened?)

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Description of the nature of the injury, exposure, or illness (What you see – signs and symptoms)

.....

Description of the treatment given (What did you do?)

.....

Name of witnesses

1.	2.
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Arrangements made relating to the worker (return to work/medical aid/ambulance/follow-up)

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Provided worker handout	Yes <input type="checkbox"/> No <input type="checkbox"/>	A form to assist in return to work and follow-up was sent with the worker to medical aid	Yes <input type="checkbox"/> No <input type="checkbox"/>
Alternate duty options were discussed	Yes <input type="checkbox"/> No <input type="checkbox"/>		
First aid attendant's name (please print)	First aid attendant's signature		
Patient's signature			