**First Aid Injury Report**

|  |
| --- |
| **General** |
| Workplace Location |  |
| Injured Persons Name |  |
| Home Address |  |
| Date of Birth |  | Gender | [ ]  Male [ ] Female [ ]  Other |
| Occupation |  |
| Employers Name |  |
| Employers Address |  |
| **Details of Injury** |
| Date of Injury |  | Time of Injury | [ ]  AM[ ]  PM |
| The exact location where the injury occurred |  |
| Reason for Presentation | [ ]  New Injury [ ]  Aggravated Injury [ ]  Recurring Injury[ ]  Illness [ ]  Other |
| Body Part Injured |  | Nature of Injury / Illness | [ ]  Bruise/contusion[ ]  Cardiac problem[ ]  Cold/flu[ ]  Concussion[ ]  Dislocation/subluxation[ ]  Fracture [ ]  Inflammation / swelling[ ]  Loss of consciousness[ ]  Overuse injury[ ]  Respiratory problem[ ]  Skin injury [ ]  graze[ ]  cut[ ]  blisters[ ]  Sprain e.g. ligament tear[ ]  Strain e.g. muscle tear[ ]  Other  |
| **Details of Treatment** |
| Treatment Provided by First Aid Officer | [ ]  Yes[ ]  No | Comments: |
| Follow Up Treatment Provided/Recommended | [ ]  Yes[ ]  No | Comments: |
| Doctor / Medical Facility Attended: |  |
| Date Attended |  | Medical Certificate Received | [ ]  Yes[ ]  No |
| Treatment (e.g., X-Ray, Medication, Ultrasound, Ice, CPR) |  |
| Further consultations / hospitalisation required: | [ ]  Yes [ ]  No | Injury Management Required: | [ ]  Yes[ ]  No |
| **Name of Witnesses** | 1 | 2 |
| **Contact Number For Witnesses** | 1 | 2 |
| **Name of Person(s) Who Provided First Aid** |
| Person 1 |  | Signature |  |
| Date |  | Time |  |
| Person 2 |  | Signature |  |
| Date |  | Time |  |