



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) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Initial reporting date and time (yyyy-mm-dd) (hh:mm) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Follow-up report date and time (yyyy-mm-dd) (hh:mm) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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)

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

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Name of witnesses

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

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