First Aid Incident Report Form

This form should be completed as soon as practical after the incident. When completing this form, please provide as much detail as possible. On completing this form, it must be attached to the patient's confidential medical form.

PATIENT'S NAME: _____

INCIDENT LOCATION: _____

INCIDENT DATE: _____/_____/_____ INCIDENT TIME: _____

EXAMINATION FINDINGS:_____

_____

_____

_____

CAUSE OF INCIDENT:_____

_____

_____

CHECKED MEDICAL FORM BEFORE ACTION TAKEN? YES / NO

TREATMENT ADMINISTERED: _____

_____

_____

_____

IS MEDICAL ASSISTANCE NECESSARY? YES / NO
IF YES, DETAILS: _____

_____

WITNESS' NAME: _____

WITNESS'ADDRESS: _____

WITNESS' SIGNATURE: _____

Location: _____Date of incident: ___/____/___Time _____am/pm

Signed off by management when corrective actions have been adopted and monitored.

Management signature_____ Date of sign off_____