CARRUS

First Aid Report

Employment Details

Employee's Full Name: _____

Department/Location: _____

Position Held: _____

Treatment Details

Date of Treatment: _____

Time of Treatment: _____

Person giving First Aid: _____

Nature of the Injury: _____

_____

_____

_____

Treatment Provided: _____

_____

_____

_____

Has the accident / Injury been recorded in the Accident report form? Yes ☐ No ☐

Please note that all accidents / injuries and near misses must be reported in the accident investigation form

Signed by Aiding person: _____ Date: _____

Signed by Injured person: _____ Date: _____

Signed by HSO: _____ Date: _____