FIRST AID REPORT (R-1)

ASSURANCE
CONSTRUCTION & SERVICES

CONFIDENTIAL TO BE FILLED OUT BY A FIRST AIDER.
WHEN COMPLETE IMMEDIATELY GIVE TO ONE RESPONSIBLE FOR SAFETY RECORDS

AFFECTED WORKER

NAME	PHONE	HIRE DATE

DATE & TIME OF INCIDENT		DATE & TIME REPORTED	

TOWN/CITY	PROVINCE	WORKSITE
	ALBERTA	

BODY PART		LEFT		RIGHT	

TYPE OF INJURY

AMPUTATION			CRUSH			REPETITIVE MOTION INJURY		
ANIMAL/INSECT BITE			ELECTRICAL SHOCK			RESPIRATORY		
ASPHYXIATION			EYE IRRITATION			SKIN IRRITATION		
BURN- HEAT			FRACTURE			SPRAIN/STRAIN		
BURN-CHEMICAL			FROSTBITE			OTHER:		
CONCUSSION			IMPALEMENT			OTHER:		
CONTUSION/BRUISE			LACERATION/CUT			OTHER:		

WHAT WAS THE CAUSE OF THE INJURY OR ILLNESS?

HAS THE WORKER HAD THIS HAPPEN BEFORE, IF YES WHEN?

WAS FIRST AID PROVIDED? (circle one)	YES	NO

DESCRIBE THE FIRST AID PROVIDED

NAME OF FIRST AIDER			
CERTIFICATE NUMBER		QUALIFICATIONS	

WERE THEY TAKEN FOR MEDICAL AID? (Circle one)	YES	NO

WHERE	
MED. PROFESSIONAL	
WCB CLAIM NUMBER (For office use)	

***NOTE: The WCB Act requires that an Employer's Report (C040) be submitted if (a) there is LOST TIME beyond the day of the accident; (b) the worker is put on MODIFIED WORK; (3) there is a FATALITY; (4) there is a PERMANENT DISABILITY; (5) there Is a need for MEDICAL ATTENTION beyond first aid including ongoing prescriptions, eyewear etc. The worker must fill out the WCB Workers Report (C060)**