City of Kelowna

Occupational Health & Safety Branch

First Aid Treatment Record

0180-70 FATR Rev 2 12-06-25

Incident #: **New** ❑ **Follow-up** ❑ **#** _____

(If Follow-up record Original incident #) **#** _____

1. EMPLOYEE INFORMATION:

Name:		**Occupation:**	
Department:		**Supervisor:**	

2. DATE & TIME OF INJURY OR ILLNESS:

Date of Injury or Illness:		**Time of Injury or Illness:**	**AM**	**PM**
Date Reported:		**Time Reported:**	**AM**	**PM**
Date of Follow-up:		**Time Reported:**	**AM**	**PM**

3. ATTENDANT ON DUTY:

First Aid Attendant (please print)		**First Aid Certificate Number:**	

4. HISTORY OF INJURY OR ILLNESS: (What Happened?)

If this is a follow up treatment refer to and quote the original incident.

5. NAME OF WITNESSES:

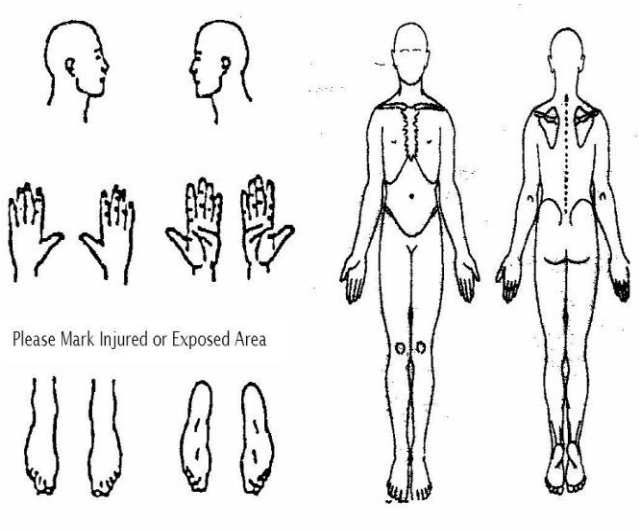
1.
2.

6. PATIENT'S CHIEF COMPLAINT:

7. PHYSICAL FINDINGS:

8. LOCATION OF INJURY

❑ head	❑ face	❑ ear	❑ eye
❑ nose	❑ mouth	❑ cheek	❑ neck
❑ shoulder	❑ chest	❑ abdomen	❑ arm
❑ elbow	❑ forearm	❑ hand	❑ finger
❑ back	❑ hip	❑ buttock	❑ leg
❑ thigh	❑ knee	❑ shin	❑ ankle
❑ foot	❑ toe	❑ other	❑ _____



9. TREATMENTS:

10. COMMENTS:

11. REFERRAL OF CASE & REMARKS: (CHECK ✓)

☐ RETURN TO WORK	☐ FIRST AID FOLLOW-UP	☐ MEDICAL AID
Notify the worker's Supervisor if the worker is returning to work and will be performing modified duties as a result of the injury.	Inform the injured worker of the follow-up times and dates. Workers MUST attend follow-up treatments when requested to do so by the FAA.	Notify the worker's Supervisor if the worker requires transportation to medical aid. **WORKPLACE INJURY ❑ YES ❑ NO**

****NOTE: If this is a workplace injury and worker is sent for medical aid they must report the injury to WorkSafeBC by calling Teleclaim, Mon-Fri, 8am – 4pm. 1-888-967-5377**

12. DATE & TIME EMPLOYEE SHALL RETURN FOR FIRST AID FOLLOW-UP:

_____

13. SIGNATURES:

Patient's: _____ Date: _____

First Aid Attendant: _____ Date: _____