



# CLS Health and Safety Program

## First Aid Record

CLS Location \_\_\_\_\_

Sequence number \_\_\_\_\_

Name	Occupation
Date of Injury or illness (yyyy-mm-d)	Time of injury or illness (hh:mm) am <input type="checkbox"/> pm <input type="checkbox"/>
Initial reporting date and time (yyyy-mm-d)	Follow-up report date and time (yyyy-mm-dd) am <input type="checkbox"/> pm <input type="checkbox"/>

**Description of how the injury, exposure, or illness occurred (What happened?)**


**Description of the nature of the injury, exposure, or illness (What you see—signs and symptoms)**


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


**Name of witnesses**

1. _____	2. _____
----------	----------

**Arrangements made relating to the employee (return to work/medical aid/ambulance/follow-up)**


Alternate duty options were discussed (Location light duties) Yes <input type="checkbox"/> No <input type="checkbox"/>	CLS Medical and Return to Work information form to assist in return to work and follow-up was sent with the worker to medical aid. Yes <input type="checkbox"/> No <input type="checkbox"/>
First aid attendant's name (please print)	First aid attendant's signature
Patient's signature	