



This record must be kept by the employer for three (3) years. This form must be kept at the employer's workplace. Do **NOT** submit to WorkSafeBC unless requested by a WorkSafeBC officer (fax 604 233-9777; toll-free 1 888 922-8807).

Sequence number

Name	Occupation
Date of injury or illness (yyyy-mm-dd)	Time of injury or illness (hh:mm) a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
Initial reporting date and time (yyyy-mm-dd) a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Follow-up report date and time (yyyy-mm-dd) a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
Initial report sequence number	Subsequent report sequence number(s)

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

<p>.....</p> <p>.....</p> <p>.....</p>
--

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

<p>.....</p> <p>.....</p> <p>.....</p>
--

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

<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
--

Name of witnesses

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

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

<p>.....</p> <p>.....</p> <p>.....</p>
--

Provided worker handout Yes <input type="checkbox"/> No <input type="checkbox"/> Alternate duty options were discussed Yes <input type="checkbox"/> No <input type="checkbox"/>	A 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	