INDUSTRIAL SAFETY TRAINERS inc.

FIRST AID REPORT

This form must be completed by the First Aider or designate and kept with the first aid box.

WORKER IDENTIFICATION		
Last Name	First Name	Department
Occupation	Date of Injury (DD / MM / YY)	
Type of Injury		
Description of Accident		
Name of Witness (es)		
Nature/Location of Treatment		
Name of First Aider		

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