

Date of illness/injury (yyyy-mm-dd)		Time of illness/injury AM PM		Date reported to first aid (yyyy-mm-dd)		Time reported to first aid AM PM	
Time of arrival at first aid (walk in) AM PM		Time on scene (if applicable) AM PM		Employee's name		Date of birth (yyyy-mm-dd)	
Employer's name			Employee's doctor			Contact person	
<b>AVPU</b> A – Alert V – Responds to voice P – Responds to pain U – Unresponsive		<b>GCS</b> <b>Eye opening response</b> 4 Spontaneously 3 To speech 2 To pain 1 No response <b>Best verbal response</b> 5 Orientated 4 Confused 3 Inappropriate words 2 Incomprehensible sounds 1 No response <b>Best motor response</b> 6 Obeys commands 5 Localizes pain 4 Withdraws from pain 3 Flexes to pain (decorticate) 2 Extends to pain (decerebrate) 1 No response				Chief complaint	
AVPU (circle)		GCS LOC		Mechanism of injury/history of illness			
Total		Total		Total		Total	
E		E		E		E	
V		V		V		V	
M		M		M		M	
Time		Time		Time		Time	
Resp.							
SPO2							
Pulse							
Pupils = / +							
Skin							
Allergies				Medications			
Interventions <input type="checkbox"/> Airway cleared <input type="checkbox"/> Maintained <input type="checkbox"/> OPA <input type="checkbox"/> Suction <input type="checkbox"/> Ventilated <input type="checkbox"/> PKT mask <input type="checkbox"/> BVM <input type="checkbox"/> Control bleed <input type="checkbox"/> Tourniquet applied (time) _____ <input type="checkbox"/> Oxygen applied (time) _____ LPM _____				Definitive treatment <input type="checkbox"/> Spinal motion restriction <input type="checkbox"/> Immobilized <input type="checkbox"/> Splinted <input type="checkbox"/> Additional treatment (please specify)			
Recommendations <input type="checkbox"/> First aid followup <input type="checkbox"/> RTW <input type="checkbox"/> Medical aid				Transport <input type="checkbox"/> ETV <input type="checkbox"/> Industrial ambulance <input type="checkbox"/> BC ambulance <input type="checkbox"/> Air evacuation <input type="checkbox"/> Other (please specify)			
F.A.A. name		F.A.A. signature		OFA certification no.		OFA level <input type="checkbox"/> 1 <input type="checkbox"/> TE <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Name of witness (please print)				Employer's mailing address			
Employee's signature				City/town		Postal code	

