WORKERS' COMPENSATION BOARD OF BC

PLEASE SEND THIS REPORT TO THE OFFICE COVERING WORKER'S WORKPLACE AREA

FIRST AID REPORT

Please answer all questions and complete this report in ink.

Supplementary to Employer's Form 7 "Employer's Report of Injury or Occupational Disease."

The following questions to be completed in full by First Aid Attendant, or other person rendering first aid. Please sign and attach to the Form 7 for submission to the office covering the worker's workplace area.

WCB Head Office: 6951 Westminster Highway
Richmond BC V7C 1C6

Please Note:
Facsimile (fax) copies are acceptable at all WCB offices in British Columbia.

7A

WORKER'S LAST NAME *(please print)* *Mr. Ms. Mrs. Miss*				EMPLOYER'S NAME *(as registered with the Board)*	
First name(s)		Middle initial		Mailing address	
Mailing address				City	Postal code
City		Postal code		Location of plant or project where injury occurred	Postal code
Telephone number	Social insurance number	Date of birth *Month Day Year*		Type of business	Employer's telephone number
Weight	Height *Feet Inches*	Marital status ❒ Married ❒ Single ❒ Other		Worker's occupation	Worker's personal health number from BC CareCard

1. Date and time of injury *(Month)* *(Day)* 20 , at a.m. / p.m.

2. (a) Time of reporting to First Aid Attendant *(Month)* *(Day)* 20 , at a.m. / p.m.

   (b) How did the worker get to the First Aid Room? *(walk, stretcher, truck, etc.)* ______

   (c) By whom was the injured worker brought to the First Aid Room? ______

   (d) Was the worker unconscious following injury or exposure? ❒ Yes ❒ No If yes, for how long? ______

   Was this based on personal observation? ❒ Yes ❒ No

3. (a) Please describe injuries found ______

   (b) Please give nature of initial first aid rendered ______

   (c) Please give dates and nature of subsequent treatments ______

4. When did the worker leave to see a physician or qualified practitioner? *(Month)* *(Day)* 20 , at a.m. / p.m.

   Did worker report to a physician or qualified practitioner as soon as advised? ❒ Yes ❒ No

5. Location and approximate distance to nearest physician or qualified practitioner

6. Please give name and address of physician or qualified practitioner

7. By what means was the worker transported to a physician or qualified practitioner?

First aid attendant's signature		Date
First aid certificate *(if any)* dated	Certificate number	Grade
Worker's statement of injury		

☛ **ADDITIONAL INFORMATION CAN BE RECORDED ON THE REVERSE SIDE OF THIS REPORT.**
Please see the reverse side of this report for telephone and fax numbers.

Worker's last name	First name	Middle initial	Social insurance number	Claim number

Worker's personal health number from BC CareCard									

Additional information

Personal information on this form is collected for the purposes of administering a worker's compensation claim by the Board in accordance with the ***Workers Compensation Act*** and the ***Freedom of Information and Protection of Privacy Act***. For further information, please contact the Board's Freedom of Information Coordinator at 6951 Westminster Highway, Richmond, BC, V7C 1C6, or telephone 604 279-8171.

Mailing address for report and all claims correspondence: Workers' Compensation Board of BC
PO Box 8940 Stn Terminal
Vancouver BC V6B 1H9

Fax number: Local 604 233-9722 or toll free within BC 1 888 922-8803.

For additional information on the Workers' Compensation Board, please refer to our web site at **www.WorkSafebc.com**.

Telephone information

Call the **Lower Mainland and Vancouver Island** Call Centre at 604 231-8888 or toll free within BC 1 888 967-5377.

Call the **BC Interior and North** Call Centre at 250 717-4301 or toll free within BC 1 888 922-6622.

Occupational Disease Services, call 604 276-3007 or toll free within BC 1 888 967-5377(extension 3007).