FSAR First aid / Accident Form

Full Name of FSAR member _____

Date of Injury: _____ Time: _____ Am ☐
Day Month Year PM ☐

Date Injury reported: _____ Time: _____ AM ☐
Day Month Year PM ☐

Description of Injury / Accident:

_____

_____

_____

Description of where the Injury / Accident occurred:

_____

_____

_____

Cause of the Injury / Accident:

_____

_____

_____

Was any First Aid Provided: Yes ☐ (if yes complete remainder of form) No ☐

Description of First Aid Provided:

_____

_____

Name of First Aider: _____

First Aid Qualifications: Emergency First Aider ☐ Standard First Aider ☐ Other ☐

Remarks: _____

_____

This Form shall be kept on file for a minimum of 3 years from the date of Injury / Accident