

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 address or fax number on page 2.

WORKER'S LAST NAME (please print) <i>Mr. Ms.</i> <i>Mrs. Miss</i>			EMPLOYER'S NAME (as registered with WorkSafeBC (the Workers' Compensation 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 <i>Month Day Year</i>	Type of business		Employer's telephone number	
Weight	Height <i>Feet Inches</i>	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	Worker's occupation		Worker's personal health number from BC CareCard	

7
A

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? (<i>walk, stretcher, truck, etc.</i>) _____						
(c) By whom was the injured worker brought to the First Aid Room? _____						
(d) Was the worker unconscious following injury or exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long? _____						
Was this based on personal observation? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	WorkSafeBC 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 WorkSafeBC in accordance with the **Workers Compensation Act** and the **Freedom of Information and Protection of Privacy Act**. For further information, please contact WorkSafeBC'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: WorkSafeBC
 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 WorkSafeBC, please refer to our web site at **WorkSafeBC.com**.

Telephone information

Call Centre: 604 231-8888 or toll free within BC 1 888 967-5377.

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