Telephone Triage - check box: ☐

FIRST AID TREATMENT FORM

EMPLOYEE NAME _____ SS# _____ PHONE # _____

DEPARTMENT _____ JOB TITLE _____

SUPERVISOR'S NAME _____ PHONE # _____

DATE OF INJURY _____ DATE OF TREATMENT _____

DIAGNOSIS _____

TREATMENT GIVEN _____

_____

IF REFERRED TO CLINIC OR PHYSICIAN:

NAME OF CLINIC OR PHYSICIAN _____ PHONE # _____

WORK/DISABILITY STATUS:

☐ Employee may work regular duties, without restrictions, full time. **FIRST AID-No Forms Needed.**

☐ **Employee has been referred to Physician for work status. Please complete Form RM-75 and RM-135.**
(OSHA reportable)

DISCHARGES:

☐ This is a FIRST AID Injury. No follow-up is needed.

☐ This is a FIRST AID Injury. Follow-up as noted here: _____

☐ The patient was discharged from FIRST AID care on: _____

Comments: _____

_____

First Aid Provider Signature _____ Date: _____
Employee Health 805/654-3813

To Employee:
Please report to (or call) your H. R. representative or supervisor before returning to workplace to discuss your treatment plan and status. **Please provide a copy of this form to your supervisor.**

Employee Signature _____ Date: _____

Distribution for Work Comp Referral:	**White** - Risk Management **Pink** - Medical Provider	**Green** - Supervisor **Goldenrod** - Employee	**Yellow** - File
For FIRST AID ONLY:	**White** - Employee	**Green** - Supervisor	**Yellow** - File