First Aid Report

Guest Injury or Accident

Return First Aid Report to Your Immediate Supervisor

DATE: _____ TIME: _____ am / pm

Museum of Transportation LOCATION: _____

Victim's Name: _____ male / female AGE: _____

Victim's Phone Number: (___) _____

Your Name: _____

Your Phone Number: (___) _____

MUSEUM OF TRANSPORTATION

Contacted EMS: YES NO

Consent for First Aid:

_____ Yes
_____ No
_____ Guardian consented
_____ Unconscious
_____ Minor without guardian

Witnesses: Name/Phone # (If available)

One: _____

(___) _____

Two: _____

(___) _____

Three: _____

(___) _____

DESCRIPTION ACCIDENT/INJURY:

_____

_____

_____

_____

_____

_____

_____

DESCRIPTION OF FIRST AID GIVEN:

_____

_____

_____

Additional Comments:

_____

_____

_____

_____

Signature: Victim's Signature: