

Medical Emergency Response Report

Date and time of report _____ Date and time of incident _____

Name of victim _____

Victim's employee no. _____ Location of emergency _____

Equipment involved in emergency _____

What was the victim's problem? _____

Did the injury or illness involve any of the following? (Check all that apply.)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> CPR | <input type="checkbox"/> An electric shock | <input type="checkbox"/> Hand (R) (L) |
| <input type="checkbox"/> Automated external defibrillation
(use of an AED) | <input type="checkbox"/> Burn | <input type="checkbox"/> Foot (R) (L) |
| <input type="checkbox"/> Breathing assistance | <input type="checkbox"/> Head | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Eye (R) (L) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> A fall | <input type="checkbox"/> Arm (R) (L) | _____ |
| | <input type="checkbox"/> Leg (R) (L) | _____ |

What happened?

List all responders who helped with the emergency

What happened to the victim? _____

Name of person completing report _____

Date _____