Ventura County Community College District

FIRST AID REPORT

(For on-the-job injuries only)

To: Workers' Compensation, District Administration Center

From: Student Health Center ☐MC ☐OC ☐VC

Patient Name: _____ Date of Service: _____

Patient SS#/ID: _____ Date of Injury: _____

Reason for visit: _____

Body Part:

☐Cervical	☐Shoulder	☐Knee
☐Thoracic	☐Elbow	☐Lower Leg
☐Lumbar	☐Wrist	☐Ankle
☐Hip	☐Hand	☐Foot
☐Ribs	☐Nail	☐Toe
☐Eye(s)	☐Finger	☐Scalp

Treatment: _____

_____

_____

_____

_____

_____

Status:

☐ Return to work immediately ☐ Return to work next shift on _____

☐ Referred to personal physician

☐ Referred to medical facility: _____

_____

Follow-up Required: ☐No ☐Yes, on _____

Billing:

☐Standard first aid visit: $_____

☐Medical supplies: $ _____

Medical Treatment/Referral provided by: (Print)_____

Signature: _____

(First Aid Provider)

For District Use Only:

☐Supervisor's Report Date_____ ☐DWC 1 Date _____

☐Submitted to Keenan Date _____ ☐Payment Authorized Date _____