|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Witness Statement | | | | | | |
|  | | | | | | |
| The information contained on this form will be used to identify causes of injuries. It should be completed by the injured employee and any witnesses to a work-related injury or accident. Submit this form with the Accident Investigation Report. This is not part of the Workers Compensation claim reporting process. | | | | | | |
| Injured Employee Name | | | | Employee Number | | Date of Incident |
|  | | | |  | |  |
| Was the accident the result of an unsafe act or condition? What acts, failures to act, or conditions contributed to the incident? | | | | | | |
| Unsafe Act | Unsafe Condition | | Neither | |  | |
|  | | | | | | |
| Explain what you experienced and/or saw. | | | | | | |
|  | | | | | | |
| What type of injury occurred? | | | | | | |
|  | | | | | | |
| Additional Comments and Information. | | | | | | |
|  | | | | | | |
| I verify that I witnessed the accident as described above. The statements made were given by me freely, without coercion from my supervisor or the injured employee. | | | | | | |
| Witness Name | | Witness Signature | | | | Date Form Completed |
|  | |  | | | |  |
|  | | | | | | |
| To obtain an additional supply of this form, contact the Safety Coordinator. | | | | | | |