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| Witness Statement |
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|  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 |
|   |  |  |
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| To obtain an additional supply of this form, contact the Safety Coordinator. |