



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
DEPARTMENT OF ADMINISTRATION  
STATE EMPLOYEES WORKERS' COMPENSATION  
One Capitol Hill  
Providence, RI 02908-5866

**ACCIDENT WITNESS AFFIDAVIT**

Date:

This is to certify that I was a witness to the accident/incident of:

Name:

Date of Injury:

Time of Injury:

Location of Injury:

Description of accident/incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Witness (Please print your name)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Telephone Number