Accident Witness Statement

Injured Employee's name:_____

Last First Middle

Name of Witness: _____ Home Phone#_____

Last First Middle Cell Phone # _____

Job Title of Witness:_____How long employed here?_____

Home Address of Witness: _____

City: _____State_____ Zip Code: _____

Location of Accident_____ _____

Address(Name of Building) Area (loading dock, bathroom, etc)

Date of Accident:_____Time of Accident:_____

Describe fully how accident occurred:(include event that occurred immediately before the accident):

_____

_____

_____

_____

Describe injury sustained (be specific about body part(s) recurring):

_____

_____

Recommendation on how to prevent this accident from recurring_____

_____

Supervisor of Witness:_____

Signature of Witness:_____Date:_____

Form may be copied as needed Form revised 09-19-2018