WITNESS STATEMENT

You were listed as a Witness to a work-related injury. Please complete this form and return within 24 hours to your supervisor.

NAME OF INJURED EMPLOYEE:

NAME AND POSITION OF WITNESS:

DATE OF INJURY: TIME OF INJURY: A.M. P.M. SHIFT:

ACCIDENT LOCATION:

DID YOU SEE THE INCIDENT OCCUR? **YES** **NO** WERE YOU PRESENT AT THE TIME OF THE INCIDENT? **YES** **NO**

DESCRIBE WHAT THE INJURED EMPLOYEE WAS DOING IMMEDIATELY BEFORE THE INCIDENT AND HOW THE INCIDENT OCCURRED:

DID YOU SEE THE INJURED EMPLOYEE WEARING OR USING SAFETY EQUIPMENT AT THE TIME OF THE INCIDENT? **YES** **NO**

IF YES, WHAT SAFETY EQUIPMENT WAS THE EMPLOYEE USING?

I HAVE CAREFULLY REVIEWED THE INFORMATION CONTAINED IN THIS WITNESS STATEMENT. TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE AND ACCURATE STATEMENT OF RECOLLECTION OF THE EVENTS.

SIGNATURE OF WITNESS: **DATE:**