Accident Witness Statement

(To be completed by accident witness)

Injured employee's	name:			
		Last	First	Middle
Name of witness: _			PH#	<u> </u>
	Last	First	Middle	
Job title of witness	:			
Home address of w	itness:			
City:			State:	Zip Code:
Location of accider				
	Ac	ddress/Name of building		Area (bathroom, etc.)
Date of accident: _				Time of accident:
Describe fully how	accident	t occurred. (ii	ncluding ever	nts that occurred
•		•	icidania ever	its that occurred
immediately before	e the acc	ciaentj:		
Describe hodily init	irv slista	ained (he snec	rific about bo	dy part(s) affected):
bescribe bodiny inje	ary saste	anied (be spec		ay part(s) arrected).
Pacammandation a	an haw t	to provent this	s assidant fra	am rooccurring
Recommendation of	אטוו ווכ UW l	to prevent this	s accident if C	ini reoccurring.
Name of Witness's	Supervi	sor:		PH#
		Last	First	
Signature of Witne	ss:			Date: