"WITNESS" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION
[To be completed by Employee]

Name (First) of witness	(Last)	(Middle initial)

Address: (Street, City, State, Zip)

Phone Number(s): Home: ( )
Other: ( )

Job Title:	Department:	Shift:

Did the injury occur on the employer premises?
☐Yes ☐ No If No, Where?

LOCATION:

Date of Accident / /	Normal Shift Start Time ☐AM ☐ PM	Time of Accident ☐AM ☐PM	
Accident was reported to:			

Description of Accident (Describe how the injury occurred, be specific) (include body parts assumed to be injured)

Drawing of Accident:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true.
Fraud Notice: Any Individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of the law and may also be subject to criminal and civil penalties.

Witness Signature: **Date:**
Original Signature Required.