

Witness Account of Injury Form

Your Name: _____

Department: _____ Supervisor: _____

Date of Accident: _____ Time of Accident: _____

Please answer the following questions and return this form to your supervisor. This form must be completed if you witnessed the injury or accident. Your input is critical in helping us keep our work conditions safe. If writing assistance is required please use the witness's exact words when completing this form on their behalf.

Where did the accident occur?

When did the accident occur?

How did the accident occur? Please be specific with as much detail as possible.

Did the accident cause the employee to be injured? Yes? No?
(If yes, please explain how the injury occurred.)

Was anyone else directly involved in the accident? Yes? No?

If yes, who were they employed by; Company? _____

Did the accident cause anyone else to be injured? Yes? No?
(If yes, please state who **and** how)

Who:

How:

Did the accident occur while the employee was on duty? Yes? No?
If not, please explain when & where the injury occurred.

Did the accident occur while they were performing your job? Yes? No?
If not, please explain.

Please read the following statement:

The above statement is an accurate report of how my injury occurred. I understand that I am obligated to complete this form in its entirety in the most accurate manner possible.

Witness Name (print)

Completion Date

Witness Signature