Accident Witness Statement

The information contained on this form will be used to help identify the cause of this accident. The form should be completed by any witness to the accident and submitted with the Supervisor First Report of Incident.

Accident Date and Time:	**Date and Time Reported:**	**Was Anyone Injured?** **Yes** **No**
Injured Employee Full Name:	**Job Title:**	**Department:**
Explain what you saw.		
What type of injury occurred to the employee?		
Describe any factors contributing to the accident that you observed?		
Additional comments and information		
I verify that I witnessed the accident as described above. The statements made were given by me freely, without coercion from my supervisor or the injured employee.		
Witness Name	**Phone number or email address**	
Witness Signature	**Date**	