



Workers' Compensation Accident Witness Statement

_____ (To be completed by accident witness) _____

Injured employee's name: _____
Last First Middle

Name of witness: _____ Ph# _____
Last First Middle

Job title of witness _____ How long employed here? _____

Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____
Address/Name of building Area (bathroom, etc.)

Date of accident: _____ Time of accident: _____

Describe fully how accident occurred: (including events that occurred immediately before the accident):

Describe bodily injury sustained (be specific about body part(s) affected):

Recommendation on how to prevent this accident from recurring: _____

Name of Witness Supervisor: _____ Ph# _____
Last First

Signature of Witness: _____ Date: _____