

## WITNESS STATEMENT OF ACCIDENT/INJURY/ILLNESS

To be completed by each witness and given to their supervisor immediately following the incident.  
**Your participation is important in helping to prevent future injuries**

Witness Name:		Injured Persons Name:	
Witness Phone #:		Witness Email:	
Witness Address:			Witness Position:
City:	State:	Zip:	
Witness Supervisors Name:			
Incident School/Department:			
Specific Location of Incident:			
Date of Incident:		Time:	AM <input type="checkbox"/> PM <input type="checkbox"/>
Names of Additional Witnesses:			
Describe fully how the incident occurred (Including all events that occurred immediately before and after the incident):			
Describe all injuries suffered (be specific about body location and body parts):			
If applicable, was any personal protective equipment in use at the time of the incident?			
What do you think could be done to prevent this incident from recurring?			
Date:		Witness Signature:	