**Department of Human Resources**
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# Work-Related Incident and Injury Witness Statement

| | | |
|---|---|---|
| WITNESS | *DATE/TIME OF WITNESS REPORT* | *NAME OF WITNESS* *WITNESS PHONE NUMBER* |
| TIME & PLACE | *DATE/TIME OF INCIDENT* | *INCIDENT LOCATION* |
| INCIDENT INFORMATION | TYPE OF INCIDENT<br>☐ INJURY OR ILLNESS<br>☐ MOTOR VEHICLE INCIDENT<br>☐ PROPERTY DAMAGE<br>☐ NEAR-MISS<br>ARE YOU AWARE OF ANY PREVIOUS INCIDENTS INVOLVING THIS EMPLOYEE?<br>_____ | IF ACCIDENT, DID YOU **SEE** WHAT HAPPENED?<br>☐ YES<br>☐ NO<br>IF YES, WHAT DID YOU SEE? PLEASE BE SPECIFIC: |
| INCIDENT DESCRIPTION | DESCRIBE WHAT HAPPENED: | |
| | PLEASE RELAY ANY ADDITIONAL INFORMATION ABOUT THE INCIDENT: | |

| | |
|---|---|
| WITNESS NAME ▶ | DATE SIGNED |
| WITNESS SIGNATURE<br>SIGN HERE | DEPARTMENT/OFFICE |