MATHEWS LOCAL SCHOOL DISTRICT
STATEMENT OF WITNESS TO ACCIDENT/INJURY

I. INCIDENT IDENTIFICATION INFORMATION

Name of Employee Alleging Incident____ Shift______________________

Occupation____Department____________________________________

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Please answer each of the following questions and promptly return your completed statement.

Your Name____ Your Occupation__________________________

Your Address____ Your Telephone Number ( ) ______ - _______

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Did you see an accident/injury involving the above employee? ☐ Yes ☐ No

If not, how did you learn about the accident/injury? ____

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If you did see an accident/injury occur: Date of Accident_____________Time of Accident__________ ☐am ☐pm

Describe what you observed: ____

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___________________________________ ___________________________________ ___________________

Signature Your Name Printed Date

PLEASE COMPLETE THIS FORM IMMEDIATELY AND RETURN TO SUPERVISOR.