

Witness Accident Statement

This form must be completed and turned in to Lita Biggs, Director of Business Operations within 5 days of the actual injury.

Your Full Name: _____ Date of Birth: _____

Your Home Address: _____

Your Home Phone Number: _____ Your Cell Phone Number: _____

Your Email Address: _____

Your Employer: _____ Occupation: _____

Length of time with current employer: _____ Relationship to injured party: _____

Date of Workplace Accident: _____ Time of Accident/Injury: _____ a.m/ p.m

Location of Accident: _____

Where were you when accident occurred? _____

Names and contact information for all who witnessed or were involved with accident: _____

In your own words, please describe the accident in detail: _____

Complaints of injured party. Be specific. _____

Has injured party ever had similar complaints in the past? If so, please explain. _____

Any additional comments: _____

Date

Signature