

Witness Accident Statement

This form must be completed and turned in to McGee Stoller, HR Leader, 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 Occupation: _____

Your Employer: _____

Length of time with current employer: _____

Relationship to injured party: _____

Date of Workplace Accident: _____

Time of Accident: _____ circle am or pm

Location of Accident: _____

Where were you when the accident occurred: _____

Names and contact information for all who witnessed or were involved in the 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

Printed Name