Mt. Diablo Unified School District
1936 Carlotta Drive • Concord, CA 94519

WITNESS REPORT OF ACCIDENT/INJURY

(Please print and completely answer each question.)
(Use separate sheet of paper if additional room is necessary.)

Witness name:	Today's date:
Witness work site or address:	
Witness telephone number(s) Home: Work: Cell:	
Date of accident/injury you witnessed:	Time of accident/injury you witnessed:
Location of accident/injury you witnessed:	
Identity of MDUSD employee(s) involved:	
Brief description of accident/injury:	
Witness signature	**Date**

Any person who makes or causes to be made any fraudulent statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Date employer received report:	Received by:

- If you are a MDUSD employee, please return this form to your Manager/Supervisor.
- If you are not employed by MDUSD, please return this form to Mt. Diablo Unified School District, Attn: Workers' Compensation Office, 1936 Carlotta Drive, Concord, CA 94519.

Revised: 10/11