



**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
<b>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.</b>		
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.