EMPLOYEE / WITNESS STATEMENT

____Employee **____Witness**

TO BE COMPLETED BY THE EMPLOYEE CLAIMING / INVOLVED or WITNESSED:
____ INJURY ____ILLNESS _____VEHICLE ACCIDENT ____ INCIDENT

Employee's Name: _____ Employee ID #: _____

Job Title: _____ Cell Phone #: _____

Department's Name: _____ Supervisor's Name: _____

Date of Incident: _____ Time: _____ (am/pm)

Location/Address of Incident: _____

Part of Body Injured or Illness: _____
(if applicable)

Did incident occur while performing regular/normal job duties? ___ Y ___ N
If No, Explain
_____
_____

Detail Description of Incident: _____
_____
_____
_____
_____
_____
_____
_____

Was Employee wearing required Safety / Personal Protective Equipment ____Y ___N
_____ _____
(if applicable)

Were there any witnesses to the accident? ___Y ___N List names please:
_____
_____

Employee Signature: _____ Date: _____

Submit Report to the Human Resource Department. HR – 7 Rev 0.