

**Witness Statement Form
for Work Related Injuries**

Name of Witness: _____

Home Address: _____

Telephone: _____

Business Address: _____

Date of Accident: _____ Time of Accident: _____ AM or PM

Location of Accident: _____

How close were you when the accident occurred (in feet): _____

Did you see the accident? _____

Who, if anyone was injured? _____

Describe what happened: _____

In your opinion , what caused the accident? _____

How could this accident have been prevented? _____

Were there other witnesses to this accident? _____ If so, please list names:

Witness Signature: _____ Date: _____