The Power in Personnel®

WITNESS REPORT

CLIENT LOCATION: _________________________________ DATE: _________________

INJURED EMPLOYEE'S NAME (Last, First) ____

WITNESS #_____ NAME (Last, First, Middle Initial) ______________________________________

SHIFT: _______ DEPARTMENT: ______________ SUPERVISOR: ____________________

INCIDENT DATE: _______________ TIME: ___________ AM / PM

STATEMENT OF FACTS IN THIS INCIDENT

I SAW THE INCIDENT OCCUR: YES _____ NO _____
I WAS WORKING WITH THE INJURED PERSON: YES _____ NO _____
WHAT WAS THE INJURED PERSON DOING?
____

____

WHERE WERE YOU IN RESPECT TO THE INJURED EMPLOYEE? __________________________

____

WHO WERE THE OTHER WITNESSES?
____

____

WHAT DID YOU SEE OR HEAR HAPPEN?
____
____
____

WHAT CAUSED THE INCIDENT &/OR INJURY?
____

WHAT PROTECTIVE EQUIPMENT (PPE) DID THE INJURED EMPLOYEE HAVE ON?
____

WHAT PART OF THE BODY DID THE EMPLOYEE INJURE? _______________________________

I SWEAR THAT EVERYTHING I'VE REPORTED ON THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE.

_______________________________________ ___________________________________ AM / PM
Witness Signature Date Time

ATTACHMENT 4