WITNESS STATEMENT

(Completion of all form fields is mandatory)

Witness Name:		Job Title/Department:	
Work number:		Cell number:	
Home address:			
	(Street address)	*(City, State)*	*(ZIP)*

Accident location:			
Weather Conditions:			
Date of Accident:		Time of Accident:	

Describe how accident occurred (including events that occurred immediately before the accident)

Describe bodily injured sustained (be specific about body part(s) affected)

Recommendation on how to prevent this accident from recurring

Witness Signature _____ Date _____

Workers' Compensation Insurance **Return to: WCI@sfasu.edu** **Revised: September 1, 2023**

INSTRUCTIONS:
1.This form should be completed by the person giving the statement.
2. Be as specific and complete as possible.
3. Except for the witness signature, the statement should be typewritten, if possible. If it must be handwritten, PLEASE PRINT to ensure legibility.
4. If the space provided on the form is insufficient please attach additional information.