



WITNESS' ACCIDENT / INJURY INVESTIGATION REPORT

WITNESS INFORMATION

Witness' Name _____ Phone Number _____

INJURED EMPLOYEE INFORMATION

Employee Name _____ Relation to the Employee _____

ACCIDENT INFORMATION

Date of Accident/Injury _____ Time of Accident/Injury _____

Location of Accident/Injury _____

Severity of Accident/Injury _____

Detailed narrative description of the accident. (How did the accident occur?)

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, or who files a statement of claim containing any false or misleading information, can be guilty of committing a felony.

By typing my name below, I acknowledge this as my signature, affirming the accuracy of the provided information and agreeing to be bound by the terms of this document.

Witnesses Signature _____