Accident Witness Statement

(To be completed by the accident witness.)

Injured employee's name: _____ _____
First Middle Last

Name of witness: _____

Job title of witness: _____ How long employed here? _____

Home address of witness: _____ Phone # _____

City: _____ State: _____ Zip Code: _____

Is witness any relation to the injured employee? _____ If yes, what relation? _____

Location of accident: _____
Address/name of building; area(classroom, loading dock, etc.)

Date of accident: _____ Time of accident _____a.m. / p.m.

Describe fully what you saw and heard (including events that occurred immediately before the accident):

_____

_____

_____

_____

_____

Describe bodily injury sustained by the injured employee (be specific about body part(s) affected):

_____

_____

Name of witness' administrator/supervisor: _____ Phone # _____
First Last

Signature of witness: _____ Date: _____

Administrator/Supervisor: Send completed form to…
BCPS – Office of Risk Management, 6901 Charles Street, Bldg. B, Towson, Maryland 21204
Phone: 443-809-4133 Fax: 410-337-0160