DEPARTMENT OF HUMAN RESOURCES
OFFICE OF RISK MANAGEMENT

Witness Statement

Injured Party's Name: ____

Witness' Name: ____

Witness Residence Address: ________________________ City: ____________ State: _____

Zip Code: _________ Residence Telephone #: (   ) ____________________

Witness Position/Occupation: __________________________________

Witness Employer: ____

District Extension:_______________ Did you witness the accident: Yes No

Date of accident: _____________________ Time: _________________ a.m. p.m.

Specific point at location where accident occurred (if not an AVC location, provide name of location & address; include room number or other description): ____

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Describe how the accident occurred and who or what was involved (use backside or additional sheet if necessary): ____

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Any other information regarding the accident? ____

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Witness signature: ________________________________ Date: ___________________