

STATEMENT OF WITNESS TO ACCIDENT

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INCIDENT IDENTIFICATION INFORMATION

NAME OF EMPLOYEE ALLEGING INCIDENT

TITLE / ROLE

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SHIFT

DEPARTMENT

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WITNESS STATEMENT

Your name was provided as a witness by the employee listed above. In order to complete a timely and thorough investigation of this incident, please provide the following details and submit your completed statement as soon as possible.

WITNESS NAME

WITNESS TITLE / ROLE

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WITNESS ADDRESS

WITNESS PHONE

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DID YOU SEE AN INCIDENT INVOLVING THE ABOVE EMPLOYEE?

YES

NO

IF NOT, HOW DID YOU LEARN ABOUT THE ACCIDENT?

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IF YOU DID SEE THE ACCIDENT OCCUR:

LOCATION OF INCIDENT

DATE OF INCIDENT

TIME

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PLEASE DESCRIBE WHAT YOU SAW:

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NAME

SIGNATURE

DATE

WITNESS			
REPORT RECEIVED BY			

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