# Temple I S D
# Witness Report of Accident, Injury, or Illness

**Instructions:** Please Print. Fill in all blanks. If a blank does not pertain to your accident, injury, or illness, write "N/A" in that blank. **Complete immediately and return this form to your supervisor.**

Name: ______________________________

Mailing Address: ______________________________

______________________________

**Home Phone #** ______________ **Work Phone #** ______________

**Job Title:** ______________ **Work Location -** ______________

| Did you witness the accident, injury, or illness? |
|---|
| Name of employee who you witnessed having the accident, injury, or illness: |
| Date and Time of the accident, injury, or illness: |
| Campus or worksite location of accident or illness: |
| Worksite location of accident, injury, or illness (stairs, hall, classroom, etc.)- |
| Describe what you saw or heard? |
| What do you believe was the cause of the accident/injury? |
| What do you believe could have prevented the accident, injury, or illness? |
| If required, was the injured worker using the proper safety equipment? |
| Was the injured worker following required safety procedures? |
| List names of other witnesses if any: |
| Additional comments: |

The information I have provided either in my own writing or verbally for the purpose of this form is true and correct. I understand that providing false or misleading information or omission of information on this report or any other form relating to this claim of injury, accident, or illness may result in termination of my employment.

Signature of Witness: ______________________ Date: ______________

Reader or Interpreter: ______________________ Date: ______________

02/03/03