T2 INSURANCE SOLUTIONS LLC

YOUR WORKERS COMPENSATION SOURCE

Witness Report

Name of injured worker:_____ Date of injury:_____
Name of witness:_____ Department:_____

Location of the accident:_____
Did you actually see the accident happen?_____
If "no", what did you witness?_____
What exactly happened?_____

Was it clear that the employee was hurt?_____
If "no", then why not?_____
What part of the body appeared injured?_____
Have you heard the employee complain of a similar injury/illness?_____

Has the employee mentioned other on the job injuries before?_____

Are you aware of other accidents/injuries the employee has had before?_____

Other observations:_____

Witness' Signature:_____ Date:_____

Manager's Signature:_____ Date:_____