



# Witness Statement

\_\_\_\_\_  
*Name of BRIDGE HR Staffing's Client Employing Injured Worker*

## COMPLETE ALL BLANKS

Name of Witness: \_\_\_\_\_ Date of This Report: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Witness's Employer: \_\_\_\_\_ Witness Phone #: \_\_\_\_\_

Name of Injured Worker: \_\_\_\_\_ Injured Worker's Employer: \_\_\_\_\_

Date of Incident: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Time of Incident: \_\_\_\_\_

Client Where Incident Occurred (for staffing companies only): \_\_\_\_\_

Address Where Incident Occurred: \_\_\_\_\_

Are you related to the injured worker? (circle one) NO / YES If "YES," list your relation: \_\_\_\_\_

How long have you known the injured worker? \_\_\_\_\_

Did you actually see the incident? \_\_\_\_\_

Explain, in detail, what you saw or know regarding this incident: \_\_\_\_\_

\_\_\_\_\_

List the names of any other persons who may have information regarding this incident: \_\_\_\_\_

\_\_\_\_\_

Is there any other information that you know that would assist in providing a fair evaluation of this incident?

\_\_\_\_\_

\_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date Signed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

By signing this form, you acknowledge your understanding that any person who knowingly submits false or fraudulent information is guilty of a crime and may be subject to fines and/or confinement in state prison.

**\*\*\*\*REPORT DUE WITHIN 24 HOURS OF ACCIDENT\*\*\*\***