Kennesaw State University
Department of Environmental Health & Safety

INCIDENT WITNESS STATEMENT

Instructions: This form should be completed witness to an accident that results in injury or illness. The form should be as soon as possible (24 hrs) and submitted to the injured employee's immediate supervisor.

To be completed by accident witness

Injured employee First Name		Injured employee Last Name			
Witness First Name		Witness Last Name			
Witness Home address:				Tel #	
City		State		Zip Code	
Witness Job Title		Witness Department			
Witness Supervisor Name				Supervisor Tel #	

Employment Type	**Employment Category**	**Length of Employment**
❑ Faculty ❑ Staff ❑ Student ❑ Contractor ❑ Others_____	❑ Regular full time ❑ Regular part time ❑ Seasonal ❑ Temporary	❑ 1-6 mos. ❑ 6 mos. – 1 yr. ❑ 1 yr. – 5 yrs. ❑ 5 yrs. (or more)

Describe the incident

Date of Incident		Time of the incident		Shift	❑ 1st ❑ 2nd ❑ 3rd
Location of the Incident (Address)		Specific Location of the incident (e.g office, mechanical room, shop)			
Did the incident involve property damage?	❑ Yes ❑ No	Was a motor vehicle involved in this incident?		❑ Yes ❑ No	

Affected body Part:

❑ Head/face ❑ Eye ❑ Neck/shoulder ❑ Arms/elbow ❑ Right Hand ❑ Left Hand ❑ Wrist/Head ❑ Rib
❑ Fingers ❑ Chest/lower trunk ❑ Hip ❑ Back ❑ Leg/knee ❑ Foot/ankle ❑ Toes
❑ Other _____

Describe, step-by-step, how the incident occurred:

What would you recommend to prevent this accident from recurring:

Witness Signature		Date	