Appendix D page 1

Van Buren County Arkansas <u>EMPLOYEE ACCIDENT WITNESS REPORT</u>

INSTRUCTIONS: SUPERVISOR TO COMPLETE FORM; FOR WORKER'S COMPENSATION INJURIES (LOSS TIME)

Employee Witness Name: ____
(last) (first) (m.i.)

Phone Number: (   ) ______________________

1) DEPARTMENT: ______________________

2) JOB TITLE: ______________________

3) DATE OF ACCIDENT: __________________

4) TIME __________ AM/ PM

5)Where did it happen? ____

6) Did you see it? ___YES ___ NO

7)Where were you when the accident occurred? ______________________________

____

8) Was weather a factor? ___ YES ___ NO

If yes, describe conditions ____

9) Conditions of accident area ____

10) What precautions had been taken? ______________________________________

____

11) Did any defects contribute to the accident? (name and describe) ____________________

____

____

12) Did the injured person (s) actions contribute to the accident? ____________________
(If yes, describe how)

____

____

13) Name (s) of injured ____

____

Appendix D page 2

14) Give Name sand Addresses of Other Witnesses

____

____

15) Describe how the accident occurred: ______________________________

____

____

____

____

16)Are you a personal friend or relative of the injured person(s)? (If yes, please state relationship)

____

____

WITNESS SIGNATURE ______________________________ DATE__________

SUPERVISOR'S SIGNATURE ______________________________ DATE__________

If more room is needed, use the space below.

____

____

____

____

____

____

____