



Witness' Report of Employee Illness / Injury

Please type or print clearly.

Date of Report: _____

Witness to Accident:

Name of Witness: _____

City Employee? ☐ Yes ☐ No

Job Title: _____

Work Site: _____

Contact Phone Number: _____

Name of Injured Employee: _____ Site: _____

Job Title: _____

Date of Injury/Illness: _____ Time: _____ ☐ a.m. ☐ p.m.

Site and Exact Location of Accident: _____

Witness Description of Accident:

In Your Opinion, What Do You Think Was the Primary Cause of this Accident:

The Contributing Causes to the Accident:

Report Completed By: _____ Title: _____

Signature _____

Date _____