APPALAACHIAN STATE UNIVERSITY
Accident Witness Statement

(To be completed by accident witness – Please print all but your signature.)

Injured Employee's Name: _____

Witness Name: _____

Dept./Job title of Witness: _____

Length of ASU Employment: _____

Your Supervisor: _____ Work Phone #: _____

Location of Accident: _____

Date of Accident: _____ Time of Accident: _____

Describe fully how the accident occurred: (including events that occurred immediately before the accident).

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Your recommendation on how to prevent this accident from recurring:

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Signature of Witness: _____ Date: _____