

WITNESS INJURY/INCIDENT REPORT FORM

Town of Marana

THIS FORM IS TO BE COMPLETED BY THE WITNESS TO AN INJURY/ ACCIDENT AND FORWARDED TO THE EMPLOYEE'S SUPERVISOR WITHIN 24 HOURS OF THE INJURY

DEPARTMENT:

1. NAME OF AFFECTED EMPLOYEE AND JOB TITLE:

2. DATE AND TIME OF INJURY/INCIDENT:

3. PROVIDE DETAILS OF WHAT YOU WITNESSED: (Include your location to the employee injured, equipment involved, job duty performing, and details to fully explain)

4. PROVIDE NAMES OF ALL OTHER WITNESSES AND ANY OTHER PERTINENT INFORMATION:

5. FURTHER INFORMATION YOU WOULD LIKE TO INCLUDE REGARDING THE INJURY/INCIDENT:

I CERTIFY THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

PRINT WITNESS NAME

WITNESS SIGNATURE and DATE