MOUNT VERNON SCHOOL DISTRICT NO. 320

STATEMENT OF WITNESS

You have been identified as a witness of an incident in the MVSD workplace that caused an employee to be injured. Please complete the form and provide a reply to all questions. Sign completed form and forward it to your supervisor for their signature. Questions about this form may be directed to the Personnel Department.

Witness Name:_____ Date of Birth_____

Home Phone _____ Street Address: _____

City:_____ Zip:_____

School/Site: _____ Position (teacher, I/A, etc.) _____

1. Did you witness an injury occur in the workplace? ☐ Yes ☐ No

2. If "Yes", who was injured? _____

3. Give date, hour and place it occurred. _____

4. If "No", how did you become aware of an incident in the workplace? _____

_____

5. Was anyone else present at the time of the incident?_____

6. Describe as well as you can what happened. Please include the activity the injured worker was doing when the incident occurred and the conditions of the workplace. You may use the back of form for additional writing space. (If you did not see the incident, state what knowledge you have of the incident.)

_____

_____

_____

_____

_____

_____

7. What was the part of body injured?_____

8. Did the worker complain after the injury? ☐ Yes ☐ No

9. If so, when? _____

10. What did he/she say? _____

11. Did the worker complain of a similar condition prior to the incident? ☐ Yes ☐ No

12. Anything else you would like to add that you were not asked? ☐ Yes ☐ No
If "Yes", please use space below and the back of this form for additional writing space.

_____

_____

_____

13. Your Relationship to the injured worker: Co-worker ☐ Family ☐ Other ☐ Please specify_____

_____ _____ _____ _____

Employee's Signature | Date | Supervisor's Signature | Date

02/10