

Supplemental Witness Statement

Privacy Notice: State law requires that you be informed that you are entitled to: (1) request to be informed about the information collected about yourself on this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge. To request this information, contact hrcompbenefits@tamu.edu or (979) 862-1718.

INSTRUCTIONS This statement should be complete by a supervisor or willing employee who personally witnessed a work-related injury and sent in with the First Report of Injury or as soon as possible thereafter.

Name of Claimant	
Name of Individual Providing Statement	
Please check one: <input type="checkbox"/> Supervisor <input type="checkbox"/> Employee	
Department Contact	Phone
Department	Mail Stop

The claimant referenced above was possibly involved in a work-related on _____ (indicate date) about _____ a.m./p.m. If you have firsthand information, please answer the questions listed below and return this form by fax (979) 847-8546 to the Total Compensation Benefits Office

Describe in your own words what happened and what you observed. Be as specific as possible.
Describe what part of the body you observed to be injured.

Signature of Witness

Date

<p>SUBMIT FORM TO: Total Compensation-Benefits Office hrcompbenefits@tamu.edu (as attachment) Fax (979) 847-8546 Please do not submit hard copy to HR</p>	<p>NEED HELP? Benefits Services (979) 862-1718 hcompbenefits@tamu.edu</p>
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