HUMAN RESOURCES
TEXAS A&M UNIVERSITY

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 Benefits@tamu.edu or (979) 862-1718.

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

Injured Employee	Department
Name of Individual Making Statement	
This statement is from the: ☐ Witness ☐ Supervisor of Injured Employee ☐ Injured Employee ☐ Other_____ ☐ HR Liaison	Body Part(s) Injured
Date of Injury	Approximate Time of Injury ☐ A.M. ☐ P.M.

Describe what you observed:

_____ _____
Signature of Individual Making this statement Date

_____ _____
Individual Making this Statement (PRINTED) Contact Phone Number

_____
Contact Email Address

SUBMIT FORM TO:
Benefit Services
Benefits@tamu.edu (for attachment)
Fax (979) 862-3128
Please do not submit hard copy to HR

NEED HELP?
Benefit Services
(979) 862-1718
benefits@tamu.edu