



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 Employee-Relations@tamu.edu or 979.862.4027.

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.

(Please do not abbreviations on any fields).

Injured Employee		Date
Department (<i>no abbreviations – print only</i>)		UIN
Witness Name Making Statement		
This statement is from the: <input type="checkbox"/> Witness <input type="checkbox"/> Supervisor of Injured Employee <input type="checkbox"/> Injured Employee <input type="checkbox"/> HR Liaison <input type="checkbox"/> Other (name) _____		Body Part(s) Injured
Date of Injury	Approximate Time of Injury _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	

Describe what you observed

Witness Signature of Making this statement

Date

Name of Witness Making this Statement (*printed*)

Contact Phone Number

Contact's Email Address

NEED HELP?
979.862.4027 | Employee-Relations@tamu.edu
DO NOT SUBMIT TO HR