



### 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](mailto: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:		Body Part(s) Injured	
<input type="checkbox"/> Witness	<input type="checkbox"/> Supervisor of Injured Employee	<input type="checkbox"/> Injured Employee	
<input type="checkbox"/> Other _____	<input type="checkbox"/> HR Liaison		
Date of Injury		Approximate Time of Injury <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	

Describe what you observed:

\_\_\_\_\_  
Signature of Individual Making this statement

\_\_\_\_\_  
Date

\_\_\_\_\_  
Individual Making this Statement (PRINTED)

\_\_\_\_\_  
Contact Phone Number

\_\_\_\_\_  
Contact Email Address

<p><b>SUBMIT FORM TO:</b> Benefit Services Benefits@tamu.edu (for attachment) Fax (979) 862-3128 <b>Please do not submit hard copy to HR</b></p>	<p><b>NEED HELP?</b> Benefit Services (979) 862-1718 benefits@tamu.edu</p>
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