Division of Human Resources
& Organizational Effectiveness

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 ocrm@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
UIN	Department ***(no abbreviations – print only)***
Witness Name Making Statement	
This statement is from the: ☐ Witness ☐ Supervisor of Injured Employee ☐ Injured Employee ☐ HR Liaison ☐ Other_____ (Name)	Body Part(s) Injured
Date of Injury	Approximate Time of Injury _____ ☐ A.M. ☐ P.M.

Describe what you observed:

_____ _____
Witness Signature of Making this statement Date

_____ _____
Witness Making this Statement *(printed)* Contact Phone Number

_____
Contact's Email Address

NEED HELP?
Organizational Consulting & Resolution Management
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Fax: 979.862.3610
ocrm@tamu.edu
DO NOT SUBMIT TO HR