# DEPARTMENT OF PUBLIC SAFETY
# WITNESS STATEMENT

| Incident Information | |
|---|---|
| Witness Name: | |
| Job Title: | |
| Division/Bureau/Company: | |
| Address: | |
| Telephone Number: | |
| Name of injured employee/person: | |
| Date and Time of Incident: | |
| Incident location: | |

What were you doing at the time of the incident:

What was the employee involved in the incident doing at the time of the occurrence?

Did you see the incident? ☐Yes ☐No
What did you see?

Signature

Date