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| n: [] On-Site [] Off-Site Overtime Involved s and/or worksite description: | 1?[] Yes [] No |) | Injury / Illness / | , Q F L | ŒHolody VP∜ar | rt(s) Affected: |
| s and/or worksite description. | | | | | | |
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| WITNESS STATEMENT FORM | | | | | | | | |
|--|---|-----------------|----------|--|--|--|--|--|
| To be completed by incident witness: | | | | | | | | |
| Information about the person making thi | s statement: (Please print or | write clearly.) | | | | | | |
| First name | Last name | | | | | | | |
| Job title | _ Department | Division | | | | | | |
| Department Manager | Department Supervisor | | | | | | | |
| Describe exactly what you observed, regarding this incident. (Use additional sheets if needed) | | | | | | | | |
| Date of Injury / Illness | Time of incident | | _AM / PM | | | | | |
| Location of incident | | | | | | | | |
| Other witnesses | | | | | | | | |
| Statement | | | | | | | | |
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| Witness signature | | Date/Time | | | | | | |
| | Box below to be completed by Dept./Div. representative: | | | | | | | |
| | Statement received by (print name and signature) | | | | | | | |
| | Date/time statement received | | | | | | | |