

Witness Name: _____
(FIRST) (LAST)

Witness' statement: (describe what witness saw)

"Witness claims that _____

_____."

Was first aid administered on site? YES _____ NO _____

If yes, describe: _____

Was treatment sought at an Occupational Health Clinic? YES _____ NO _____

If yes, give name, location, and date seen: _____

Was treatment sought at hospital/other off-site location? YES _____ NO _____

If yes, give name, location and date seen: _____

Did employee refuse medical treatment? YES _____ NO _____

Injured Party's Signature Date

Witness' Signature Date

Supervisor's/Coordinator's Signature Date

***Human Resources Coordinator To Complete:**

Date Report Received: _____ Action Taken: _____

Was there any exposure to Bloodborne Pathogens? YES _____ NO _____

Investigation Conducted? YES _____ NO _____ If yes, describe: _____

Recorded on MIOSHA Log? YES _____ NO _____

Human Resources Signature Date