1775 Spectrum Drive • Lawrenceville, GA 30043
Phone: 770-963-7732 • Fax: 770-963-5754

Workers' Compensation Witness Statement

Witness Name: **Telephone #:**

Department:

Employee Name:

Date of Accident: **Time of Accident:** ☐ AM ☐ PM

Where did accident occur?

Address

City *State* *Zip Code*

Description of how the injury or illness / health condition occurred:

Print Name (Witness)

Signature (Witness)

Date