Mail form to:
P.O. Box 9000
146-148 Forest Road
St. John's, NL
A1A 3B8

Call us at:
t 709.778.1000
t 1.800.563.9000

Fax form to:
f 709.778.1302
Visit us at:
workplacenl.ca

Statement of Witness

Worker's name ______________________ **Claim number** ______________

Witness name ______________________

Address ______________________

City/Town **Province** **Postal Code** **Telephone Number**

1. Did you witness an incident in the workplace? ______________________

If Yes, give date, hour and place it occurred. ______________________

If not, how did you become aware of an incident in the workplace? ______________________

____

2. Was anyone else present at the time of the incident? ______________________

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3. Describe as well as you can what happened. (If you did not see the incident, state what knowledge you have of same.)

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4. What was the part of body injured? ______________________

____

5. Did the worker complain after the injury? ______________________

If so, when? ______________________

What did he/she say? ______________________

6. Did the worker complain of a similar condition prior to the incident? ______________________

7. Comments: ______________________

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Signature: ______________________ Date: ______________________