

Pitt County Schools Accident Witness Statement

(To be completed by Adult Witness Only – Please Print)

RM Use Only	
STATE Claim Number	LOCAL Claim Number
Date Received	
Confirmed/File <input type="checkbox"/> Yes <input type="checkbox"/> No	

Witness Information:

Witness Name: _____
Work Site: _____ Employee Number: _____
Work Phone Number: _____
Personal Phone Number: _____
Email Address: _____

Employee Incident/Injury Information: (Complete the following information based on what you personally observed)

Employee's Name: _____
School/Site: _____
Area/Location: <small>(where incident/accident occurred)</small> _____
Date of Occurrence: _____ Time of Occurrence _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Based on what you personally observed, describe fully how the accident occurred: <small>(include events that occurred immediately before and after the accident)</small>

By my signature, I certify that the statements provided on this form are true and accurate.

Signature: _____ Date: _____

Any person who knowingly makes false claims or statements, or conceals any material fact in order to receive or assist others to obtain workers' compensation benefits, may be subject to criminal penalties.