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**SEC**

SAFETY ENGINEERING  
& CLAIMS MANAGEMENT

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**ACCIDENT WITNESS REPORT**

Witness Name: \_\_\_\_\_

Work Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

Witness Email Address: \_\_\_\_\_

Job Title: \_\_\_\_\_ Shift Start Time: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Location of Accident: \_\_\_\_\_

Identify the Employee Involved in the Accident: \_\_\_\_\_

Did you see the accident happen? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, explain what you were told. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

If yes, describe exactly what you saw. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

List Any Other Witnesses: \_\_\_\_\_

\_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_

*Please submit all paperwork via fax or email after reporting claim online.*