Ector County, Texas
Human Resources Department

Accident Witness Statement

Instructions: The information contained on this form will be used to identify causes of injuries. The form should be completed by any witness to a work-related injury or accident.
Provide the completed form to the Benefits Coordinator at: **432-498-4011 or delia.ortiz@co.ector.tx.us**

Accident Information

Injured Employee Name	Department	Job Title	Date & Time of Accident

Witness Name	Witness Age	Witness Contact Number	Witness Address

Ector County Employee		Department	Job Title
☐Yes	☐No		
If not Ector County Employee, Employed by:			
Reason for presence at location:			

Are you related to injured employee?	☐Yes ☐No	**If yes, How?**	
How long have you known this employee?		**Did you actually see the injury?**	☐Yes ☐No
If no, how did you know about it?			
How near to the injured employee were you at the time of the injury?			
Was the accident the result of an unsafe act or condition?	☐ Unsafe act	☐ Unsafe condition	☐ Neither

Please explain in detail what you know about this injury:

What acts, failure to act, or conditions contributed to the accident?

What type of injury occurred to the employee?

Do you know of any other injury, accident, or illness that this employee has ever had?

Additional comments and information:

Witness Verification

I verify that to the best of my knowledge the statement is true and correct. The statements made were given by me freely, without coercion from my supervisor or the injured employee.

Witness Signature **Date**