DEPARTMENT OF PUBLIC INSTRUCTION
Ed. Services for the Deaf and Blind

WORKERS' COMPENSATION
ACCIDENT/INJURY INVESTIGATION
WITNESS STATEMENT FORM

DIRECTIONS: DO NOT TYPE. MUST BE HANDWRITTEN BY EMPLOYEE. PLEASE WRITE CLEARLY. FORM MUST CONTAIN AN ORIGINAL SIGNATURE OF THE EMPLOYEE SUPPLYING STATEMENT.

EMPLOYEE NAME: _____

POSITION TITLE: _____

WORK LOCATION: ___N.C. School for the Deaf _____

STATEMENT: *(Use additional paper or back of form if necessary)*

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Please list any witnesses or individuals who may have information relative to this investigation. _____

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I understand this statement will be considered part of the official investigation and that I may be called on to testify or provide written or verbal clarifying statements. The statement I have provided is an accurate account of the case to the best of my knowledge. I also understand that this is a confidential matter and that I will not discuss any portion of the investigation with anyone other than the investigators. Discussing this investigation with anyone other then the investigators may result in disciplinary action up to and including dismissal.

_____

Signature Date

Rev. 1/18/2012