UNIVERSITY OF WISCONSIN OSHKOSH

Risk & Safety Management
Workers' Compensation

Physical Address: Dempsey Hall, Rm. 214
Mailing Address: 800 ALGOMA BLVD.
OSHKOSH, WI54901-8614

Employee Injury Witness Statement

Workers' Compensation Claim Number (if known):

Injured Employee:

Date Witness Completed Form:

Name of Witness: Witness Phone:

Witness Department/Mailstop:

Did the injured worker report to you what happened: Yes ☐ No ☐

Did you witness the injury: Yes ☐ No ☐

Describe in detail what you witnessed or what the injured worker reported to you. How exactly did it happen? What did you see? What were you doing and where were you located at the time of the injury?

I certify that the above statement, to the best of my knowledge, and true and accurate:

Please sign and date: _____

Print, sign and send electronically to Risk & Safety Management:
Natalie Stenson; stensonn@uwosh.edu