HUMAN RESOURCES
550 E. Hospitality Lane Suite 200
San Bernardino, CA 92408
www.sbccd.edu

WITNESS REPORT OF INJURY/ILLNESS

SECTION I: PERSONAL INFORMATION

Witness Name	Phone #	District Employee? ☐ Yes ☐ No If yes, job title	
Home Address	City	State	Zip Code

SECTION II: FACTS RELATED TO INJURY/ILLNESS

Name(s) of Injured Employee	Date of Injury/Illness	Time of Injury/Illness _____ ☐ A.M. ☐ P.M

Location of Injury/Illness

_____

Address Building/Room # City

Did you report the incident? ☐ Yes ☐ No If yes, to whom? _____	Please name any other witnesses: _____

Describe fully how the accident occurred (including events that occurred immediately before and after the accident):

Please indicate specifically which part(s) of the body were injured:

Recommendation on how to prevent this accident from reoccurring:

Witness Signature	Date