HUMAN RESOURCES
TEXAS A&M UNIVERSITY

Supplemental Witness Statement

Privacy Notice: State law requires that you be informed that you are entitled to: (1) request to be informed about the information collected about yourself on this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge. To request this information, contact Benefits@tamu.edu or (979) 862-1718.

INSTRUCTIONS This statement should be complete by a supervisor or willing employee who personally witnessed a work-related injury and sent in with the First Report of Injury or as soon as possible thereafter.

Name of Injured Employee	Name of Individual Providing Statement
This statement is from the: ☐ Witness ☐ Supervisor of Injured Employee ☐ Injured Employee ☐ Other___________________ ☐ HR Liaison	Body Part(s) Injured
Date of Injury	Approximate Time of Injury ☐ A.M. ☐ P.M.

Describe what you observed:

____ Signature of Individual Making this statement

_______________________________ Date

____ Individual Making this statement (PRINTED)

_______________________________ Contact Phone Number

_______________________________ Contact Email Address

SUBMIT FORM TO:
Benefit Services
Benefits@tamu.edu (for attachment)
Fax (979) 862-3128
Please do not submit hard copy to HR

NEED HELP?
Benefit Services
(979) 862-1718
hrcompbenefits@tamu.edu