**WITNESS INCIDENT REPORT FORM**

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| **WITNESS INFORMATION** |

**Full Name**: [FULL NAME] **Title/Role**: [TITLE/ROLE]

**Address**: [ADDRESS]

**Phone**: [PHONE] **E-Mail**: [EMAIL]

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: [DATE]

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| **INCIDENT DETAILS** |

**Date of Incident**: [DATE OF INCIDENT] **Time**: [TIME] [ ]  AM [ ]  PM

**Location**: [LOCATION]

**Witness’s Distance From the Incident**: [DISTANCE] ft.

**Conditions That Influenced the Incident (e.g., weather, terrain)**: [DESCRIBE CONDITIONS]

**Describe the Incident**: [DESCRIBE THE INCIDENT]

*Any photographs, video recordings, or other evidence of the incident should be provided to the recipient at the time this report is filed.*

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| **INJURIES** |

**Was anyone injured?** [ ]  Yes [ ]  No

**If yes, describe the injuries**: [INJURY DESCRIPTION]

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| **PROPERTY DAMAGE** |

**Was there apparent damage to property?** [ ]  Yes [ ]  No

**If yes, describe the damages**: [DAMAGE DESCRIPTION]

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| **OTHER WITNESSES** |

**Were any other witnesses present?** [ ]  Yes [ ]  No

**If yes, enter the witnesses’ names and contact info (if available)**:

1. **Full Name**: [NAME]

**Phone**: [PHONE]

**E-Mail**: [EMAIL]

1. **Full Name**: [NAME]

**Phone**: [PHONE]

**E-Mail**: [EMAIL]

1. **Full Name**: [NAME]

**Phone**: [PHONE]

**E-Mail**: [EMAIL]

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| **POLICE / MEDICAL SERVICES** |

**Police Notified?** [ ]  Yes [ ]  No **If yes, was a report filed?** [ ]  Yes [ ]  No

**Was medical treatment provided?** [ ]  Yes [ ]  No [ ]  Refused

**If yes, where was medical treatment provided?**

[ ]  On site [ ]  Hospital [ ]  Other: [OTHER]

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| **OFFICE USE ONLY** |

**Report received by**: [FULL NAME]

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: [DATE]

**Follow-up action taken**: [FOLLOW-UP ACTION TAKEN]