Office of Human Resources

St. Olaf College
1520 St. Olaf Avenue
Northfield, MN 55057

(507) 786-3068
(507) 786-3960 FAX
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Workers Compensation Witness Statement Form

Witness Name	Witness Job Title
Witness Department	Witness Daytime Phone Number
Date of Incident	Time of Incident
Location of Incident	Employee/Student Injured
Any visible injury/illness noticed	Work Being Performed During Incident

Please describe what you witnessed

I verify this statement to be true and correct.

Witness Signature	Today's Date

Return to the College's Workers' Compensation Associate (Pat Ceas: 312 RNS) or to the HR office.