STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF ADMINISTRATION
STATE EMPLOYEES WORKERS' COMPENSATION
One Capitol Hill
Providence, RI 02908-5866

ACCIDENT WITNESS AFFIDAVIT

Date:

This is to certify that I was a witness to the accident/incident of:

Name:

Date of Injury:

Time of Injury:

Location of Injury:

Description of accident/incident:_____

_____

_____

_____

_____

_____
Witness (Please print your name)

_____
Signature of Witness

_____
Telephone Number

OFFICE#: (401) 574-8500
FAX#: (401) 574-8524
TDD#: (401) 222-2187