VAFR Injury/Illness Form – Witness

Date: _____

Witness Information	
Name:	**Agency/Department:**
Phone:	
Email:	

Incident Information
Incident Date (dd/mm/yy): ___/___/___ Time of Incident (24-hour clock):
Specific Location:
Weather Conditions:
Was PPE used by the injured individual(s): If yes, type?
Instructor(s):
Instructor(s) location when incident occurred:

Detailed Description of the Incident:
_____
_____
_____
_____
_____
_____
_____
_____

This information above is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have willfully stated in it anything which I know to be false or do not believe to be true.

Witness Signature: _____ Date: _____