Witness to Injury Statement (Form)

Witness Name: _____
Address: _____
City/State/Zip: _____
Telephone #: _____

Injured Employee's Name:_____ SS#_____

INCIDENT INFORMATION

Date, Time & Location Where Injury Occurred: Date:___/___/___ Time:____am pm
Location (Be specific):_____

Nature of Injury: _____

Part of body affected:_____

Describe fully how incident occurred (be specific as to tools or material being handled; what the employee was doing):_____
_____
_____
_____
_____
_____

Was injured employee hospitalized? _____Yes _____No _____Unknown
Hospital Name:_____
Address:_____ Telephone:_____

If known, please provide us with the name, address and telephone number of the attending physician. Name:_____
Address:_____ Telephone:_____

Please keep in mind that any person who knowingly and with intent to defraud or deceive the Bureau of Workers' Compensation or any insurance carrier, files a statement containing false, incomplete or misleading information may be subject to criminal penalties.

Witness to Injury Signature:_____ Title:_____ Date:_____