Worker’s Compensation Witness Report Form

- Name of injured employee: ______________________________
- Name of witness: ______________________________
- Location where incident occurred: ______________________________
- Date of incident: ____________________ • Time of incident: ______________

1. What were you (the witness) doing at the time of the incident?

   ____

2. How and when did you become aware of the incident?

   ____

3. What did you hear at the time of the incident?

   ____

4. Describe what you saw at the time of the incident:

5. Who else was present?

   ____

6. Please relate any additional information you have pertaining to the incident:

- Witness’s signature: ______________________ • Date signed: __________

Please use the back of this form if you need more space to provide complete information.
Fax the completed form to the Worker's Compensation Administrator at 765-496-1657. Thank you.