

WORKERS' COMPENSATION WITNESS REPORT

Injured Employee Name		Work Location		
Your Name		Do you work for the State of Illinois? <input type="checkbox"/> Yes <input type="checkbox"/> No		Work Phone
Home Address (Street)		(City/State/Zip)		Home Phone
Did you see the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date you witnessed?	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Did you know employee before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>What did you see or hear? – Be specific (use back side if necessary)</p>				
<p>Exact location of what you saw or heard</p>				
<p>Name(s) and Address(es) of any other witness(es)</p>				
<p>I CERTIFY THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE</p>				
<p>_____</p> <p>Date Completed</p>			<p>_____</p> <p>Signature of Witness</p>	
<p>_____</p> <p>Name and Title of Individual Making Report (print)</p>			<p>_____</p> <p>Print Name</p>	