WITNESS INCIDENT REPORT

To be completed and signed by witness only

This report will be submitted to the Worker's

Compensation Insurer as part of claim

Full Name: ______________________________ **Telephone Number:** ________________

Date of Incident: __________________________ **Time of Incident:** ________________

Who the accident involved:

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In your own words describe what you witnessed with as much detail as possible:

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Names of other witnesses:

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WITNESS SIGNATURE **DATE AND TIME OF REPORT**