

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:

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

Names of other witnesses:

WITNESS SIGNATURE

DATE AND TIME OF REPORT