KASB
Workers Compensation Fund, Inc.

REPORT BY EYEWITNESS

Name:_____

Name of Injured Employee:_____

Name of Witness:_____

Address:_____

Telephone Number:_____

Date of Incident:_____

In your own words, describe what you saw happen:

_____

_____

_____

Did anyone else see the accident? ☐ Yes ☐ No

If yes, please list their name(s)?_____

_____

Other comments:_____

_____

Signature of Eyewitness:_____