



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: _____