Worker's Compensation Supervisor & Witness Statement

Please complete this form as soon as possible no later than 24 hours after the incident or illness. It is the employee's responsibility to seek appropriate medical care by following administrative guidelines. Any employee who files a false report will be subject to the appropriate administrative action.

Section 1 – Employee Information

Last Name: _____ First Name: _____

Date of Injury or Illness: _____ Time: _____ □ AM □ PM

Building Name and Location: _____

Specific Location within Building: _____

Section 2 - Witness Statement

Last Name: _____ First Name: _____

In your own words what did you see happen? (Tell us how the injury or illness occurred and any equipment being used)

_____

_____

_____

_____ _____

Witness Signature Date Completed

The statements above are true to the best of my knowledge.

Section 3 - Supervisor Statement

Last Name: _____ First Name: _____

Any additional information that you would like to add regarding the injury/illness?

_____

_____

_____

Did the employee receive any medical treatment? _____ Where? _____

Have they missed any work? _____ When? _____

_____ _____

Supervisor Signature Date Completed

The statements above are true to the best of my knowledge.

Insurance Carrier: Indiana Insurance Company; P.O. Box 6063; Indianapolis, IN 46206-6063; 800-279-7221
Policy # WC9127332