

(D)

ILLINOIS COUNTIES RISK MANAGEMENT TRUST

WITNESS STATEMENT

YOUR NAME: _____

SS#: _____ HOME & WORK NUMBERS: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

NAME OF INJURED EMPLOYEE: _____

INCIDENT DATE: _____ INCIDENT TIME: _____

PLEASE EXPLAIN IN YOUR WORDS WHAT YOU SAW:

- WHERE WERE YOU AND WHAT WERE YOU DOING?
- HOW DID THE INCIDENT HAPPEN?
- HOW WOULD YOU DESCRIBE THE APPEARANCE OF THE INJURED PARTY?
- PLEASE DESCRIBE THE AREA IN WHICH THE INCIDENT OCCURRED.
- WHO ELSE WAS AT THE SCENE?
- WHAT CONVERSATION TOOK PLACE?
- DID THE INJURED PARTY SAY ANYTHING TO YOU?
- ANY OTHER INFORMATION ABOUT THE INCIDENT?

(PLEASE USE THE BACK OF THIS SHEET TO CONTINUE YOUR STATEMENT)

I UNDERSTAND THAT BY SIGNING THIS STATEMENT, I AM VERIFYING THAT ALL OF THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

SIGNATURE: _____ DATE: _____

revised 11/13/00