TRISTAR
RISK MANAGEMENT

Claim Number _____

WORKERS' COMPENSATION WITNESS REPORT

Injured Employee Name	Work Location	
Your Name	Do you work for the State of Illinois? ☐ Yes ☐ No	Work Phone
Home Address (Street)	(City/State/Zip)	Home Phone

Did you see the accident? ☐ Yes ☐ No	Date you witnessed? Time ☐ AM ☐ PM	Did you know employee before the accident? ☐ Yes ☐ No

What did you see or hear? – Be specific (use back side if necessary)

Exact location of what you saw or heard

Name(s) and Address(es) of any other witness(es)

I CERTIFY THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

_____ Date Completed

_____ Signature of Witness

Name and Title of Individual Making Report (print)

_____ Print Name

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