STATE OF MISSOURI
OFFICE OF ADMINISTRATION
RISK MANAGEMENT SECTION

WORKERS' COMPENSATION INVESTIGATION WITNESS STATEMENT REPORT

CENTRAL ACCIDENT REPORTING OFFICE
POST OFFICE BOX 809
JEFFERSON CITY, MO 65102
573-751-2837 OR 888-622-7684

TO	CASE NUMBER

It has been reported to this office that you were a witness to the injury of ______________________________.

This injury may be compensable under the Missouri Worker's Compensation Law. Your assistance in filling out this form will aid the resolution of this case. Please fill out in detail and in your own handwriting. Do not leave any blank spaces. Use the back of the sheet if necessary. Return this form immediately to your employer or the Central Accident Reporting Office. Questions? Call 573-751-2837 or 888-622-7694.

1. DID YOU WITNESS AN INJURY TO ______________________________? ☐ YES ☐ NO

2. IF SO, WHEN DID YOU WITNESS THE INJURY? GIVE DATE AND TIME:

3. EXPLAIN IN DETAIL EXACTLY WHAT YOU SAW. WHAT WAS THE EMPLOYEE DOING AT THE TIME OF THE INJURY? DID YOU NOTICE ANYTHING DEFECTIVE OR UNUSUAL CAUSING OR CONTRIBUTING TO CAUSE THE INJURY?

4. WHAT PART OF THE BODY WAS INJURED? (LEFT OR RIGHT) ☐ LEFT ☐ RIGHT

5. WERE THERE ANY OTHER WITNESSES TO THE INJURY?

6. HOW, IF AT ALL, DO YOU THINK THE INJURY COULD HAVE BEEN PREVENTED?

7. DO YOU HAVE ANY OTHER INFORMATION OR COMMENTS ON THE INJURY?

I HAVE PREPARED AND READ THE ABOVE AND DECLARE IT TO BE TRUE.

SIGNATURE	DATE