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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.

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(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: \_\_\_\_\_