GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

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

PO Box 2934 • Clinton, IA 52733-2934 • Fax 847-621-7101