INCIDENT WITNESS STATEMENT

THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT MEM-INS.COM OR BY CALLING 1.800.442.0593.

NAME OF WITNESS	DATE OF INCIDENT	TIME OF INCIDENT _____ ❒ A.M. ❒ P.M.	DATE REPORTED
DEPARTMENT	JOB TITLE		HIRE DATE
EMPLOYER (IF NOT AN EMPLOYEE)	PHONE # (IF NOT AN EMPLOYEE)		NAME OF SUPERVISOR
LOCATION OF INCIDENT			
NAME OF INJURED EMPLOYEE			
NAME OF INJURED EMPLOYEE'S EMPLOYER/MEM POLICY #	EMPLOYER'S PHONE #		
DESCRIPTION OF INCIDENT			
PHYSICAL CONDITIONS AT THE TIME OF INCIDENT			
ANY OTHER WITNESSES ❒ YES ❒ NO	NAME & PHONE #	NAME & PHONE #	NAME & PHONE #
WERE THERE OTHERS INJURED? ❒ YES ❒ NO	NAME & PHONE #	NAME & PHONE #	NAME & PHONE #
REPORT COMPLETED BY	SIGNATURE		DATE
TITLE	EMPLOYER		

Submit completed form to: Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597
Email: claims@mem-ins.com