INCIDENT WITNESS STATEMENT

THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT WWW.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 NUMBER *(IF NOT AN EMPLOYEE)*		NAME OF SUPERVISOR
LOCATION OF INCIDENT			
NAME OF INJURED EMPLOYEE			
NAME OF INJURED EMPLOYEE'S EMPLOYER/POLICY NO.	EMPLOYER'S PHONE NUMBER		
DESCRIPTION OF INCIDENT			
PHYSICAL CONDITIONS AT THE TIME OF INCIDENT			
ANY OTHER WITNESSES? ❒ YES ❒ NO	NAME	NAME	NAME
WERE THERE OTHERS INJURED? ❒ YES ❒ NO	NAME	NAME	NAME
REPORT COMPLETED BY	SIGNATURE	DATE	
TITLE	EMPLOYER		

Fax or mail completed form to:

Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1-800-442-0597