INCIDENT WITNESS STATEMENT

THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT MEM-INS.COM OR BY CALLING 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 NO. (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 NO.		
DESCRIPTION OF INCIDENT			
PHYSICAL CONDITIONS AT THE TIME OF INCIDENT			
ANY OTHER WITNESSES ❒ YES ❒ NO	NAME & PHONE NO.	NAME & PHONE NO.	NAME & PHONE NO.
WERE THERE OTHERS INJURED? ❒ YES ❒ NO	NAME & PHONE NO.	NAME & PHONE NO.	NAME & PHONE NO.
REPORT COMPLETED BY	SIGNATURE		DATE
TITLE	EMPLOYER		

Submit completed form to: MEM
P.O. Box 1810, Columbia, MO 65205

Fax: 800.442.0597
Email: claims@mem-ins.com