CITY OF HIALEAH

Workers' Compensation Witness Statement Form

INJURED WORKER
Injured Worker's Name: _____

WITNESS DETAILS
Name: _____ Last Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Contact Number: _____ Occupation: _____
Relationship to the injured worker: Co-worker _____ Family ____ Other: ____ Please Specify: _____

INCIDENT DETAILS
Date of Incident: _____ Time of Incident: _____ a.m./p.m.
Place of Incident: _____
Type of Injury (e.g. right arm, lower back): _____
Were you an eye witness? Yes _____ No _____

If Yes, please describe what you witnessed: _____
_____
_____
_____

If No, how did you become aware of the incident? _____
_____
_____

DECLARATION

Section 308 of the Workers' Compensation and injury Management Act 1981 provides that any person who fraudulently obtains of fraudulently attempts to obtain any benefits under this Act, by malingering or making any false claim or statement, and any person who, by a false or other means, aids or abets a person in so obtaining or attempting to obtain, commits an offence.

I declare that the details submitted are true and correct.

_____ _____
Signature of Witness Date